

# Due Process in Civil Commitments

Alexander Tsesis\*

## *Abstract*

*In one of its most controversial decisions to date, United States v. Comstock, the Roberts Court upheld a federal civil commitment statute requiring only an intermediate burden of proof. The statute provided for the postsentencing confinement of anyone proven by "clear and convincing evidence" to be mentally ill and dangerous. The law relied on a judicial standard established more than thirty years before. The majority in Comstock missed the opportunity to reassess the precedent in light of recent psychiatric studies indicating that the ambiguity of available diagnostic tools can lead to erroneous insanity assessments and mistaken evaluations about patients' likelihood to engage in dangerous activities.*

*I contend that the "clear and convincing standard" of proof inadequately protects patients' due process rights because civil commitment hearings can result in severe deprivations of liberty. Commitments of felons whose continued dangerousness remains in doubt raises significant due process concerns. Even more troubling is the civil commitment of individuals with no criminal records of violence to whom the clear and convincing standard also applies. In this Article, I argue that the beyond a reasonable doubt standard of proof is needed to closely scrutinize evidence of mental disease and dangerousness. The multidisciplinary approach I pursue offers a unique framework for resolving a social problem that has been inadequately described in extant legal writings. I reflect on Supreme Court precedents in light of psychiatric studies about the limited reliability of emergency commitments and set out a standard adopted from criminal proceedings to better prevent unnecessary mental hospitalization.*

---

\* Assistant Professor, Loyola University, School of Law-Chicago. Thanks to Christopher Slobogin, William Fisher, Thomas Szasz, Allan V. Horwitz, Eugene Roginsky, Stuart Kirk, Alexandra Roginsky, Nadia Sawicki, Anat Geva, Harold Krent, Richard Delgado, Patrick Murphy, Thomas Scheff, Nancy Wolff, Melesa Freerks, Joshua Rubin, and Amber Battin for helpful comments and suggestions.

*Table of Contents*

I. Introduction .....	254
II. Defining the Problem with the Clear and Convincing Standard ..	256
III. Supreme Court Standards.....	260
IV. State Statutory Schemes .....	272
V. <i>Comstock</i> and State Sexual Violent Predator Statutes .....	279
VI. Psychiatric Ambiguities .....	282
VII. Setting the Burden of Proof.....	300
VIII. Conclusion.....	306

*I. Introduction*

Mental illness diagnoses are intrinsic to civil commitment hearings.<sup>1</sup> In one of its most important decisions to date, *United States v. Comstock*,<sup>2</sup> the Roberts Court ruled that the Necessary and Proper Clause grants Congress the authority to pass laws for the forced mental institutionalization of sexually dangerous prisoners.<sup>3</sup> The statute at issue required "clear and convincing evidence" that the prisoner "suffers from a serious mental illness, abnormality, or disorder."<sup>4</sup> The majority in *Comstock* relied on *Addington v. Texas*,<sup>5</sup> which first established the clear and convincing evidentiary standard as the minimum procedural threshold for issuing involuntary commitment orders.<sup>6</sup> Rather than reexamine the analysis in that precedent, Justice Stephen Breyer, who wrote the *Comstock*

---

1. *See, e.g.*, 18 U.S.C. § 4248 (2006) (requiring a mental condition diagnosis before a civil commitment may be ordered).

2. *See* *United States v. Comstock*, 130 S. Ct. 1949, 1954 (2010) (holding that Congress has the proper authority to enact legislation concerning civil commitment under the implied powers doctrine).

3. *See id.* ("We conclude that the Constitution grants Congress the authority to enact § 4248 as 'necessary and proper for carrying into Execution' the powers 'vested by' the 'Constitution in the Government of the United States.'").

4. *See id.* (discussing the requirements of the statute).

5. *See* *Addington v. Texas*, 441 U.S. 418, 432–33 (1979) (establishing the minimum standard of proof required in order to perform a civil commitment).

6. *See id.* (holding that while the reasonable doubt standard is not required, one with a burden "equal to or greater" than that of the clear and convincing standard is necessary to fulfill due process requirements).

opinion, refused to evaluate whether the clear and convincing standard adequately protected respondents' due process rights.<sup>7</sup>

The majority in *Comstock* made short shrift of respondents' argument that the intermediate clear and convincing standard violated their due process rights.<sup>8</sup> The lack of analysis on this issue was unfortunate because the district court had ruled that only the beyond a reasonable doubt standard would suffice to secure a fair hearing about the need for forced and indefinite confinement.<sup>9</sup> The Supreme Court might have transplanted the standard it has long used in criminal cases involving an insanity defense, wherein the prosecution bears the burden of proving the requisite mental state beyond a reasonable doubt.<sup>10</sup>

During the last decade, a variety of information has surfaced in the psychiatric literature about the ambiguity and even arbitrariness of diagnoses, placing in doubt whether the clear and convincing evidence standard adequately protects respondents' due process rights.<sup>11</sup> Multiple news reports about the financial ties of prominent psychiatrists to pharmaceutical companies have further indicated the need to reassess the holding in *Addington*.<sup>12</sup>

Part II of this Article sets out some of the core problems with the current standard for civil commitment. Part III surveys Supreme Court precedents on the topic. Part IV discusses state statutory schemes for involuntary mental hospitalization, and Part V describes the current state of sexual violent predator statutes. Part VI delves into professional psychiatric literature about the ambiguity of diagnoses. Part VII synthesizes the

---

7. *Comstock*, 130 S. Ct. at 1956 ("[W]e assume for argument's sake that the Federal Constitution would permit a State to enact this statute . . .").

8. *See id.* (choosing not to decide whether the statute violated due process rights and indicating that the respondents could challenge due process compliance on remand).

9. *United States v. Comstock*, 507 F. Supp. 2d 522, 552 (E.D.N.C. 2007) ("Failure to apply the reasonable doubt standard to . . . an antecedent factual finding required for commitment under § 4248 constitutes a denial of due process . . .").

10. *But see, e.g.*, *Dixon v. United States*, 548 U.S. 1, 12 (2006) (indicating that the interpretation of precedent that required the prosecution to prove the defendant's sanity beyond a reasonable doubt was not constitutionally mandated and that Congress had overruled it in a 1984 statute).

11. *See infra* Part VI (detailing the evidence of ambiguity in psychiatric diagnoses and debates within the community regarding the proper bases for such diagnoses).

12. *See infra* notes 28–32 and accompanying text (explaining the problematic financial ties between many psychiatrists and the pharmaceutical companies, including those psychiatrists who contribute to the most commonly used diagnostic manual of the profession).

Article's findings to provide the appropriate burden of proof required to prevent the wrongful infringement of potential patients' due process rights.

The multidisciplinary approach I pursue in this Article offers a unique framework for resolving a social problem that has been inadequately described in extant legal and psychiatric writings. I reflect on Supreme Court precedents in light of psychiatric findings about the limited reliability of emergency commitments. This analysis demonstrates the need for close judicial oversight of the commitment process. Given the extensive empirical studies demonstrating the limited reliability of mental diagnoses in legal proceedings,<sup>13</sup> the *Comstock* Court might have reevaluated whether the clear and convincing standard sufficiently protects individuals against wrongful commitments. Instead the Court took the standard for granted, not so much as pausing to reflect upon it.<sup>14</sup> This Article offers a window into how current judicial construction can lead to the unnecessary confinement of thousands of people.<sup>15</sup> The way out of the morass is to develop a burden of proof standard that sets the evidentiary bar higher than the threshold the Supreme Court established.

## II. Defining the Problem with the Clear and Convincing Standard

Outside the postincarceration proceedings involved in *Comstock*, persons who are subject to involuntary commitment can be emergently deprived of their liberty based on the diagnoses of psychiatrists, emergency room doctors, and sometimes even psychiatric nurses or licensed social workers.<sup>16</sup> Emergency room observations are often perfunctory, but in

---

13. See *infra* notes 216–24 and accompanying text (discussing the problematic tendency of courts to accept psychiatric diagnoses at face value without a critical evaluation of their accuracy).

14. See *supra* note 8 and accompanying text (indicating that an evaluation of due process was outside the scope of the question before the Court).

15. See *infra* Part VI (describing the sociological studies that establish a high number of inaccurate evaluations of individuals' potential dangerousness).

16. See, e.g., FLA. STAT. § 394.467(2) (2010) (specifying who may authorize an involuntary commitment). The statute makes allowances for the constraints of places with smaller populations, providing that:

In a county that has a population of fewer than 50,000, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental and nervous disorders or by a psychiatric nurse.

*Id.*; see also KAN. STAT. ANN. § 59-2966(a) (2005) (establishing that "a written statement by

some cases they can have as profound an effect on the committed persons' lives as criminal internment.<sup>17</sup> The most recent national study of involuntary commitments found that 424,450 of the 1.7 million inpatient admissions to psychiatric units were involuntary.<sup>18</sup>

Procedural fairness requires that forced commitment be grounded in objective findings of the patient's dangerousness and serious mental illness.<sup>19</sup> The beyond a reasonable doubt standard is better suited to civil commitment hearings because it is more exacting and less likely to lead to the erroneous deprivation of liberty.<sup>20</sup> Two difficulties arise in civil commitment. The first of these involves repeated empirical findings that show psychiatrists are no better at predicting dangerous behaviors than untrained people.<sup>21</sup> The second problem judges face in applying the Supreme Court standard in *Comstock* is the ambiguity of the very concept of mental illness.<sup>22</sup> One expert on law and psychology has said, "[M]ental

---

a mental health care professional" satisfied the standard for involuntary commitment of the mentally ill). A mental health care professional is defined as a:

Physician or psychologist who is employed by a participating mental health center or who is providing services as a physician or psychologist under a contract with a participating mental health center, a licensed masters level psychologist, a licensed clinical psychotherapist, a licensed marriage and family therapist, a licensed clinical marriage and family therapist, a licensed professional counselor, a licensed clinical professional counselor, a licensed specialist social worker or a licensed master social worker or a registered nurse who has a specialty in psychiatric nursing, who is employed by a participating mental health center and who is acting under the direction of a physician or psychologist who is employed by, or under contract with, a participating mental health center.

*Id.* § 59-2946(j).

17. See *infra* note 211 and accompanying text (indicating the sizeable percentages of emergency room mental illness diagnoses that are later found to be erroneous); see also *infra* note 228 and accompanying text (indicating the percentages of emergency room diagnoses that result in involuntary commitments).

18. See DONALD M. LINHORST, EMPOWERING PEOPLE WITH SEVERE MENTAL ILLNESS 49 (2006) (describing a nationwide study of involuntary commitments in 1986).

19. See *Addington v. Texas*, 441 U.S. 418, 424–25, 432 (1979) (explaining why the clear and convincing standard is the constitutional minimum given the interests at stake).

20. See *id.* at 423 (noting that the beyond a reasonable doubt standard is used in criminal cases because it is "designed to exclude as nearly as possible the likelihood of an erroneous judgment").

21. See, e.g., Philip Saragoza & Melvin Guyer, *Psychiatric Diagnosis Delays Parole*, 37 J. AM. ACAD. PSYCHIATRY L. 127, 129 (2009) (discussing courts' acceptance of "psychologist's opinions at face value" because of the courts' unawareness "of the clinical questions and the limits of scientific evidence concerning the accuracy of predictions of future dangerousness").

22. See *infra* Part VI (explaining the ambiguities of diagnosing mental illnesses and

disorder is such a vacuous phrase that the law should consider dispensing with it as an independent criterion for intervention and instead simply identify as precisely as possible the types of mental dysfunction it wants to treat specially."<sup>23</sup> I scrutinize both of these issues in Part VI of this Article. Suffice it to say here that proof beyond a reasonable doubt is the best way to prevent these two difficulties from resulting in a violation of individuals' rights to due process.

Psychiatric testimony about such issues as whether someone is a sexually dangerous pedophile, which according to *Comstock* can be proven by clear and convincing evidence, are essential to civil commitment hearings.<sup>24</sup> Mental health professionals in the United States most commonly rely on the criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM).<sup>25</sup> The Supreme Court recognizes that the criteria in this manual are themselves subject to vigorous debates among professionals.<sup>26</sup> By its very terms the authors of the DSM recognize that using its criteria in legal proceedings risks the misuse of diagnostic information about illnesses that do not rise to the level of mental disorders for legal purposes.<sup>27</sup>

Guarding against the use of psychiatric ambiguity by requiring proof beyond a reasonable doubt is likewise needed to preserve respondents' due process rights because conflicts of interest exist among authors of the DSM. A study of 170 panel members of the DSM revision board found that ninety-five (56%) had "one or more . . . financial links to a company in the pharmaceutical industry."<sup>28</sup> Some pharmaceutical companies have found it profitable to sponsor psychiatric studies in order to increase revenues and

---

the study results that have established the risk of error by psychiatrists).

23. Christopher Slobogin, *Rethinking Legally Relevant Mental Disorder*, 29 OHIO N.U. L. REV. 497, 498 (2003).

24. *See, e.g.*, 18 U.S.C. § 4248(d) (2006) ("If, after the hearing, the court finds by clear and convincing evidence that the person is a sexually dangerous person, the court shall commit the person to the custody of the Attorney General.").

25. *See* Clark v. Arizona, 548 U.S. 735, 774 (2006) (considering the DSM-IV).

26. *See id.* (recognizing that while the DSM-IV reflects the consensus opinion, it is subject to reconsideration and revision on the basis of new research and clinical studies).

27. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL HEALTH DISORDERS: DSM-IV-TR xxxii–xxxiii (4th ed. 2000) ("When the DSM-IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks . . . . These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis.").

28. Lisa Cosgrove et al., *Financial Ties Between DSM-IV Panel Members and the Pharmaceutical Industry*, 75 PSYCHOTHERAPY & PSYCHOSOMATICS 154, 156 (2006).

influence outcomes.<sup>29</sup> In 2002, drug companies sponsored 57% of published psychiatric studies, a significant increase from the 25% such companies funded in 1992.<sup>30</sup> Of the studies sponsored by manufacturing companies, 78% had favorable outcomes, compared to the 48% with favorable outcomes among studies with nonpharmaceutical sponsorship.<sup>31</sup> Articles appearing in popular media also question the validity of research findings linked to pharmaceutical companies.<sup>32</sup> Drug manufacturers are the greatest beneficiaries of the increasing number of persons presumed to be suffering from mental disorders; for instance, the market for antidepressants is hugely successful and lucrative.<sup>33</sup>

The risk of erroneous deprivation can have severe consequences on a person subject to civil commitment.<sup>34</sup> The best opportunity to avoid erroneous deprivation of liberty is a procedurally rigorous hearing best designed to protect the individual's right to procedural fairness. A beyond a reasonable doubt standard of proof is more likely to prevent false positive results than the clear and convincing standard the Court developed in *Addington* and relied on in *Comstock*. Since it is unlikely the Court will overturn itself in the near future, state-by-state legislative reform is the best means of establishing adequate evidentiary requirements to secure the integrity of the involuntary commitment process.

---

29. See Robert E. Kelly, Jr. et al., *Relationship Between Drug Company Funding and Outcomes of Clinical Psychiatric Research*, 36 PSYCHOL. MED. 1647, 1654 (2006) (finding that pharmaceutical company-funded studies were significantly more likely to result in favorable results for those companies).

30. *Id.* at 1651.

31. *Id.*

32. See, e.g., Gardiner Harris & Janet Roberts, *Doctors' Ties to Drug Makers Are Put on Close View*, N.Y. TIMES, Mar. 21, 2007, at A1 (questioning the ability of doctors to remain objective while receiving payments from pharmaceutical companies).

33. Allan V. Horwitz has written about the interaction of mental health advocacy and pharmaceutical companies, finding that "[t]he explosive growth in sales of antidepressants is testimony to the effectiveness of this appeal. Pharmaceutical companies have also become major funders of both advocacy groups and clinical researchers." ALLAN V. HORWITZ, CREATING MENTAL ILLNESS 100 (2002).

34. See, e.g., 18 U.S.C. § 4248(e) (2006) (establishing that a person subject to involuntary commitment under the statute shall remain in the State's custody until the director of the facility where that person is held determines he is no longer dangerous).

### III. Supreme Court Standards

Involuntary civil commitment, like criminal imprisonment, raises due process concerns because it involves significant deprivation of liberty.<sup>35</sup> At the core of procedural justice is the individual's interest in remaining free from erroneous bodily restraint and being protected against arbitrary governmental abuses.<sup>36</sup> Standards of due process are meant to provide sufficiently rigorous standards of proof to prevent the wrongful deprivation of liberty.<sup>37</sup> In civil commitment hearings, procedural due process safeguards the fair development of material evidence relevant to the question of whether the respondent is dangerous and needs psychiatric treatment.<sup>38</sup> Adults subject to involuntarily hospitalization for mental disorders can challenge clinical findings and procedural adequacy.<sup>39</sup> A post-institutionalization hearing on the merits must determine whether a mental health provider can meet the statutory predicates for continued confinement.<sup>40</sup>

Following a series of sociological studies in the late 1960s and early 1970s,<sup>41</sup> the Supreme Court began to recognize the significant limitations

---

35. See *Addington v. Texas*, 441 U.S. 418, 425 (1979) ("[C]ivil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.").

36. See *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992) ("Freedom from bodily restraint has always been at the core of the liberty protected by the Due Process Clause from arbitrary governmental action.").

37. See *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976) (discussing how due process requires courts to determine the risk that state action will result in an erroneous deprivation of an entitlement).

38. See *Addington*, 441 U.S. at 426–27 (concluding that there is a threshold level of behavior necessary for civil commitment to be appropriate).

39. See *Missouri v. Nash*, 972 S.W.2d 479, 482 (Mo. Ct. App. 1998) ("The due process rights of a person are violated if the state holds a person in a psychiatric facility when the person is no longer suffering from a mental disease or defect." (citing *Foucha*, 504 U.S. at 79)).

40. See *Rodriguez v. City of New York*, 72 F.3d 1051, 1062 (2d Cir. 1995) ("[A]s a procedural matter, due process does not permit continuation of a challenged involuntary civil commitment without a hearing . . .").

41. For some of the leading sociological studies critiquing the mental health profession, see generally NICHOLAS N. KITTRIE, *THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY* (1971); LABELING MADNESS (Thomas J. Scheff ed., 1975); THOMAS J. SCHEFF, *BEING MENTALLY ILL: A SOCIOLOGICAL THEORY* (1st ed. 1966); THOMAS S. SZASZ, *IDEOLOGY AND INSANITY: ESSAYS ON THE PSYCHIATRIC DEHUMANIZATION OF MAN* (1973); THOMAS S. SZASZ, *LAW, LIBERTY, AND PSYCHIATRY: AN INQUIRY INTO THE SOCIAL USES OF MENTAL HEALTH PRACTICES* (1st ed. 1963); THOMAS S. SZASZ, *MANUFACTURE OF MADNESS: A COMPARATIVE STUDY OF THE INQUISITION AND MENTAL HEALTH MOVEMENT* (1st ed.



on freedom involved in civil commitments to mental institutions.<sup>42</sup> In one decision, the Court indicated its surprise that, given the gravity of the constitutional issues involved, there were few cases litigated about the states' power to commit mentally ill persons.<sup>43</sup> At the time, state standards for commitment varied widely.<sup>44</sup>

During the 1970s, courts increasingly reviewed complaints filed by mental patients held against their wills at public psychiatric hospitals.<sup>45</sup> This was a shift from the almost limitless discretion administrators and mental health professionals had enjoyed before.<sup>46</sup>

The landmark case placing due process limits on forced psychiatric commitments, *O'Connor v. Donaldson*,<sup>47</sup> arose when Kenneth Donaldson filed suit to be released from the Florida State Hospital, where he had been in custody for almost fifteen years.<sup>48</sup> After his father committed him in 1957, Donaldson was often kept with other patients in a locked communal room that was run like a prison.<sup>49</sup> Throughout his confinement he made frequent requests to be set free.<sup>50</sup> Uncontradicted evidence at trial demonstrated that Donaldson was neither a danger to himself or others, was never suicidal, had earned a living prior to being institutionalized, and secured a job in hotel administration after his release.<sup>51</sup> One-third of the

1970); THOMAS S. SZASZ, *MYTH OF MENTAL ILLNESS: FOUNDATIONS OF A THEORY OF PERSONAL CONDUCT* (1st ed. 1961).

42. See Aman Ahluwalia, *Civil Commitment of Sexually Violent Predators: The Search for a Limiting Principle*, 4 CARDOZO PUB. L. POL'Y & ETHICS J. 489, 497 (2006) (detailing the shift towards greater protection of individual rights in Supreme Court cases involving civil commitment beginning in the 1970s).

43. See *Jackson v. Indiana*, 406 U.S. 715, 737 (1972) ("[C]onsidering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated.").

44. See *id.* at 736–37 ("The States have traditionally exercised broad power to commit persons found to be mentally ill. The substantive limitations on the exercise of this power and the procedures for invoking it vary drastically among the States.").

45. JOHN Q. LAFOND & MARY L. DURHAM, *BACK TO THE ASYLUM: THE FUTURE OF MENTAL HEALTH LAW AND POLICY IN THE UNITED STATES* 95 (1992).

46. *Id.*

47. See *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975) (establishing the limits of state confinement of nondangerous individuals).

48. *Id.* at 564.

49. *Donaldson v. O'Connor*, 493 F.2d 507, 511 (5th Cir. 1974).

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

51. See *id.* at 568 (describing testimony at trial from Donaldson, fellow inmates, and hospital staff that established Donaldson's lack of violence and capacity to thrive outside the institution).

patients living with Donaldson were criminals, and he was afraid for his safety.<sup>52</sup> Dr. J.B. O'Connor, the hospital superintendent and Donaldson's attending physician for about eight years, knew that Donaldson had committed no dangerous acts but rejected his entreaties for freedom.<sup>53</sup>

The Supreme Court decided that "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."<sup>54</sup> The ambiguity of a mental illness diagnosis and the extent to which civilly committed patients are deprived of their liberty rendered the mere diagnosis of mental illness without a finding of dangerousness inadequate to meet due process requirements.<sup>55</sup> Social deviance may make a person the object of animus but cannot excuse restrictions on liberty.<sup>56</sup> Demonstrating an understanding that mental illness was a powerful social label that could be misapplied, Justice Potter Stewart, writing for the majority, asserted that "the mere presence of mental illness does not disqualify a person from preferring his home to the comforts of an institution."<sup>57</sup>

Chief Justice Warren Burger, who wrote a concurrence to *O'Connor*, made clear there was some connection between the confinement of involuntarily committed mental patients and criminally confined felons.<sup>58</sup> Both types of liberty deprivations raised due process concerns for the protection of individual liberty.<sup>59</sup> Burger suggested a procedural test for assessing the appropriate limits to civil confinement: "Commitment must be justified on the basis of a legitimate state interest, and the reasons for

52. *Donaldson*, 493 F.2d at 511 n.5.

53. *See id.* (establishing O'Connor's term at the hospital); *see also O'Connor v. Donaldson*, 422 U.S. 563, 568 (1975) (explaining that O'Connor had admitted to having no knowledge that Donaldson had ever committed a dangerous act).

54. *O'Connor*, 422 U.S. at 576.

55. *See id.* at 575 ("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 no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.")

56. *See id.* ("Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty.")

57. *Id.*

58. *See id.* at 580 (Burger, C.J., concurring) ("There can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law.")

59. *See id.* (indicating that due process of law is necessary for both kinds of involuntary commitment).

committing a particular individual must be established in an appropriate proceeding . . . . [C]onfinement must cease when those reasons no longer exist."<sup>60</sup> He went further in identifying a legitimate governmental interest for confinements: "[I]n the exercise of its police power a State may confine individuals solely to protect society from the dangers of significant antisocial acts or communicable disease."<sup>61</sup>

Burger wrote the majority opinion in *Addington v. Texas*, which proved to be the landmark case on the appropriate burden of proof in civil commitment cases.<sup>62</sup> In *Addington*, Burger clarified his concurrence from *O'Connor*, writing that while he saw some similarities between criminal incarceration and mental internment, he did not believe the two to be precisely analogous.<sup>63</sup> *Addington* must be analyzed in detail because of its influence on the Roberts Court's recent opinion on sexual predator post-conviction confinement, *United States v. Comstock*.<sup>64</sup> My central argument in this Article is that in *Addington* the Supreme Court failed to provide a sufficient safeguard to prevent the wrongful deprivation of a person's constitutional rights.<sup>65</sup> *Addington* created the current procedural standard for involuntary mental institutionalization.<sup>66</sup>

Mr. Addington's mother claimed that her son assaulted her.<sup>67</sup> After he was arrested for that misdemeanor his mother sought a court order for indefinite commitment.<sup>68</sup> At the trial, the state sought to demonstrate that Addington suffered from serious delusions, and two psychiatric experts testified that he was psychotic and dangerous to himself and others.<sup>69</sup>

---

60. *Id.*

61. *Id.* at 582–83.

62. See Grant H. Morris, *The Supreme Court Examines Civil Commitment Issues: A Retrospective and Prospective Assessment*, 60 TUL. L. REV. 927, 933, 938–46 (1986) (citing *Addington v. Texas* as the seminal case for establishing civil commitment procedure requirements and detailing the effect the case had on subsequent legal decisions).

63. See *Addington v. Texas*, 441 U.S. 418, 423–27 (1979) (noting that the standard of proof used in a case balances the interests at stake with the risk for error and that the balance in civil commitment cases is different than in criminal cases).

64. See *United States v. Comstock*, 130 S. Ct. 1949, 1956 (2010) (using *Addington* as a basis for the assumption that a State could constitutionally enact a statute like the one at issue).

65. See *infra* notes 296–302 and accompanying text (explaining why the standard set by the Court does not sufficiently protect due process rights).

66. See *supra* note 62 and accompanying text (describing how the *Addington* case became the baseline measurement for due process requirements in civil commitment cases).

67. *Addington*, 441 U.S. at 420.

68. *Id.*

69. *Id.* at 421.

While Addington did not contest the claim that he was mentally ill, he argued that he should not have been institutionalized since he was not dangerous.<sup>70</sup> After a jury found him to be mentally ill, Addington appealed to the Texas Court of Civil Appeals arguing that the trial judge erred by refusing to instruct jurors that the standard of proof should have been beyond a reasonable doubt.<sup>71</sup> And it is this standard that I adopt later in this Article as the appropriate one for the civil commitment process.<sup>72</sup>

Prior to the Supreme Court's holding in *Addington*, eleven states and the District of Columbia used the criminal burden of proof for mental commitment hearings.<sup>73</sup> Two state appellate courts had determined that involuntary commitment cases had to meet the beyond a reasonable doubt standard.<sup>74</sup> Twenty-five states used some version of the intermediate standard to review facts.<sup>75</sup>

The Supreme Court granted certiorari in *Addington* to decide the extent of scrutiny needed to avoid the erroneous deprivation of liberty.<sup>76</sup> The Chief Justice differentiated between ordinary civil cases, to which the preponderance of the evidence standard applies; criminal cases, which apply the beyond a reasonable doubt standard; and intermediate cases that

70. *Id.*

71. *Id.* at 421–22.

72. *See infra* Part VIII (asserting that the beyond a reasonable doubt standard is most appropriate in civil commitment cases where serious deprivations of liberty are at stake).

73. HAW. REV. STAT. § 334-60(b)(4)(I) (Supp. 1978); IDAHO CODE § 66-329(I) (Supp. 1978); KAN. STAT. ANN. § 59-2917 (1976); MONT. CODE ANN. § 38-1305(7) (1977 Supp.); OKLA. STAT. tit. 43A, § 54.1 (1978 Supp.); OR. REV. STAT. § 426.130 (1977); UTAH CODE ANN. § 64-7-36(6) (1953); WIS. STAT. § 51.20(13)(e) (Supp. 1978–1979); *In re Hodges*, 325 A.2d 605, 607 (D.C. 1974); *Superintendent of Worcester State Hosp. v. Hagberg*, 372 N.E.2d 242, 245 (Mass. 1978); *Lausche v. Comm'r of Pub. Welfare*, 225 N.W.2d 366, 369 (Minn. 1974); *Proctor v. Butler*, 380 A.2d 673, 676 (N.H.1977).

74. *Denton v. Commonwealth*, 383 S.W.2d 681, 683 (Ky. Ct. App. 1964); *In re J.W.*, 130 A.2d 64, 69 (N.J. Super Ct. App. Div. 1957).

75. ARIZ. REV. STAT. ANN. § 36-540 (1974); COLO. REV. STAT. § 27-10-111(1) (Supp. 1976); CONN. GEN. STAT. § 17-178(c) (1979); DEL. CODE ANN. tit. 16, § 5010(2) (Supp. 1978); GA. CODE ANN. § 88-501(u) (1978); 91½ ILL. REV. STAT. § 3-808 (Supp. 1977); IOWA CODE § 229.12 (1979); LA. COMP. STAT. § 28:55E (1979); ME. REV. STAT. ANN. tit. 34, § 2334(5)(A)(1) (1978); MICH. STAT. ANN. § 14.800(465) (1976); NEB. REV. STAT. § 83-1035 (1976); N.D. CENT. CODE § 25-03.1-19 (1978); N.M. STAT. ANN. § 43-1-11C (1978); OHIO REV. CODE ANN. § 5122.15(B) (West Supp. 1978); 50 PA. STAT. ANN. § 7304(f) (Purdon Supp. 1978–1979); S.C. CODE ANN. § 44-17-580 (Supp. 1978); S.D. CODIFIED LAWS § 27A-9-18 (1977); VT. STAT. ANN. tit. 18, § 7616(b) (Supp. 1978); *In re Beverly*, 342 So. 2d 481, 489–90 (Fla. 1977).

76. *See Addington v. Texas*, 441 U.S. 418, 425 (1979) (describing the question as one of the acceptable level of due process and noting that "the function of legal process is to minimize the risk of erroneous decisions").

apply a clear and convincing standard.<sup>77</sup> He found that the third standard, which examines the clarity and cogency of the evidence, is sufficient for civil commitments.<sup>78</sup> A heightened burden of proof is necessary because the "[l]oss of liberty calls for a showing that the individual suffers from something more serious than is demonstrated by idiosyncratic behavior."<sup>79</sup>

The Court gave examples of other causes of action, such as fraud, that relied on the "clear and convincing" standard of evidence.<sup>80</sup> Like civil commitment, liability for fraud may result in social stigma.<sup>81</sup> The Supreme Court subsequently determined that the "clear and convincing" standard is not even constitutionally mandated in those fraud cases that involve monetary damages for securities fraud.<sup>82</sup> Chief Justice Burger's reliance on the fraud analogy in *Addington* was misplaced. Fraud is very different from civil commitment for no less a reason than civil liability for fraud involves no deprivation of liberty.<sup>83</sup> Liability for fraud, which might result in compensatory or replevin awards,<sup>84</sup> is far less onerous than adverse rulings in civil commitment hearings, which can lead to an extended forced commitment.<sup>85</sup> The law upheld by the Court in *Comstock* allows for a virtually unlimited period of confinement, allowing a mental institution to hold a previously convicted sex offender until a mental health worker determines "the person's mental condition improves to the point where he is

---

77. *Id.* at 423–24.

78. *Id.* at 432–33.

79. *Id.* at 427.

80. *Id.* at 424.

81. See Adam F. Ingber, Note, *10b-5 or Not 10b-5? Are the Current Efforts to Reform Securities Litigation Misguided?*, 61 *FORDHAM L. REV.* S351, S372 n.145 (1993) ("[T]he interests at stake in a fraud case are elevated above the interests at stake in a mere monetary dispute. A fraud suit has the added risk of stigmatizing the defendant as a fraud, and impugning a defendant's reputation.").

82. See *Herman v. Huddleston*, 459 U.S. 375, 387–88 (1983) (choosing to apply the preponderance of the evidence standard); see also *Grogan v. Garner*, 498 U.S. 279, 291 (1991) (holding that in bankruptcy cases, the standard of proof for the dischargeability of debt is the preponderance of the evidence standard rather than the clear and convincing standard); *State v. Alpine Air Prods., Inc.*, 500 N.W.2d 788, 790 (Minn. 1993) ("We believe this elimination of elements indicates that the legislature intended that the burden of proof in a consumer fraud case would be the preponderance of the evidence standard.").

83. See generally 37 *AM. JUR. 2D Fraud and Deceit* § 355 (2010) (discussing civil liability for fraud in general).

84. See *id.* § 372 ("Personal property obtained by fraud may be specifically recovered in an action of replevin . . . . Alternatively . . . the seller may . . . maintain an action . . . for [the] value [of the property].").

85. See *infra* note 141 and accompanying text (noting that forced confinements, though periodically reviewed, may continue for a lifetime).

no longer dangerous (with or without appropriate ongoing treatment), in which case he will be released."<sup>86</sup> The Court mistakenly analogized fraud to this indefinite term of confinement.

In *Addington*, the Chief Justice also compared civil commitments to deportation cases. In an earlier case, the Court found that the drastic hardship that can result from deportation requires proof by "clear, unequivocal, and convincing evidence."<sup>87</sup> In order to demonstrate that an alien is removable, the Immigration and Naturalization Service must prove that the foreigner has been convicted of a crime involving moral turpitude, has committed an immigration violation, or entered the country without prior authorization.<sup>88</sup> In reviewing a previous conviction for moral turpitude, an immigration judge must determine whether the felonious alien was convicted for a crime punishable by at least one year of imprisonment.<sup>89</sup> This is similar to the evaluation a court will make to determine whether a convicted sex offender is subject to civil commitment.<sup>90</sup> There are, nevertheless, significant differences between immigration and civil commitment proceedings.<sup>91</sup>

Immigration court hearing officers may be required to review respondents' criminal record.<sup>92</sup> Civil commitments, other than post-conviction hearings for sexual offenders, often have nothing to do with past criminality.<sup>93</sup> Emergency commitments are covered by civil statutory

86. *United States v. Comstock*, 130 S. Ct. 1949, 1955 (2010).

87. *Woodby v. Immigration & Naturalization Serv.*, 385 U.S. 276, 286 (1966).

88. *See* 8 U.S.C. § 1227(a) (2006) (stating that an alien is deportable if "convicted of a crime involving moral turpitude," for "fail[ure] to maintain the [proper] nonimmigrant status," or for entering "the United States in violation of . . . any . . . law of the United States").

89. *Id.* § 1227(a)(2)(A) ("Any alien who is convicted of a crime involving moral turpitude . . . for which a sentence of one year or longer may be imposed, is deportable.").

90. *See, e.g., Comstock*, 130 S. Ct. at 1954 ("The federal statute . . . allows . . . civil commitment . . . if [an] individual (1) . . . 'engaged or attempted to engage in sexually violent conduct or child molestation,' (2) . . . 'suffers from a serious mental illness . . .,' and (3) 'as a result of' that mental illness . . . is 'sexually dangerous to others,' . . . would have serious difficulty . . . refraining from sexually violent conduct . . .") (quoting 18 U.S.C. § 4247(a)(5)–(6)(2006)).

91. *See United States v. Comstock*, 507 F. Supp. 2d 522, 527 (E.D.N.C. 2007) (discussing respondent's criminal record for receiving "materials depicting a minor engaging in sexually explicit conduct" prior to engaging in the civil commitment analysis).

92. *See supra* note 88 and accompanying text (discussing that the past criminal acts of aliens may result in deportation).

93. *See, e.g., O'Connor v. Donaldson*, 422 U.S. 563, 568 (1975) ("The testimony at the trial demonstrated, without contradiction, that Donaldson had posed no danger to others during his long confinement, or indeed at any point in his life. O'Connor himself conceded

provisions that require the diagnoses of future dangerous conduct based on current disposition and current mental illness.<sup>94</sup> The *Addington* test, which was reaffirmed in *Comstock*, applies to both.<sup>95</sup> In fact, respondents to involuntary mental hospitalization petitions need not have any criminal record at all.<sup>96</sup> Even where civil commitment is being sought because of a prior conviction, for offenses like the distribution of sexually explicit child pornography,<sup>97</sup> these cases substantively differ from deportation hearings. People who are removable from the United States because of a prior criminal record are not indefinitely interned but released to the country of their citizenship.<sup>98</sup> Other statutory grounds for deportation, such as overstaying the time allotted on visitor or student visas, are factually grounded.<sup>99</sup> For those sorts of proceedings, the clear and convincing standard is sufficient to evaluate the relevant evidence. On the other hand, involuntary mental hospitalization is different because the evidence is of a more subjective type about the patients' mental well-being.<sup>100</sup> Mental diagnoses, unlike determinations about visa overstays or lack of marital relationship needed to receive permanent residence, are subjects of highly controvertible assessments.<sup>101</sup>

---

that he had no personal or secondhand knowledge that Donaldson had ever committed a dangerous act.").

94. See *infra* Part IV (discussing state civil commitment statutes in detail).

95. See *infra* note 177 and accompanying text (explaining that *Addington*'s standard of proof was adopted and applied in *Comstock*).

96. See *O'Connor*, 422 U.S. at 568 (noting that a prior criminal record is not necessary for the involuntary commitment of individuals).

97. See *United States v. Comstock*, 130 S. Ct. 1949, 1955 (2010) ("[T]he Government instituted proceedings . . . against the five respondents in this case. Three of the five had previously pleaded guilty in federal court to possession of child pornography.").

98. See 8 U.S.C. § 1231(b)(2)(D) (2006) ("[T]he Attorney General shall remove the alien to a country of which the alien is a subject, national, or citizen . . .").

99. See *id.* § 1182(a)(7)(A) ("[A]ny immigrant at the time of application for admission who is not in possession of a valid unexpired immigrant visa . . . is inadmissible.").

100. See *Addington v. Texas*, 441 U.S. 418, 429 (1979) ("There may be factual issues to resolve in a commitment proceeding, but the factual aspects represent only the beginning . . . . Whether the individual is mentally ill and dangerous . . . and is in need of confined therapy turns on the *meaning* of the facts which must be interpreted by . . . psychiatrists and psychologists." (emphasis in original)).

101. Courts are very familiar with the notorious disagreements among expert psychiatric witnesses about litigants' dangerousness and sanity. See, e.g., *Barefoot v. Estelle*, 463 U.S. 880, 898–99 (1983) ("[J]urors should not be barred from hearing the views of the State's psychiatrists along with opposing views of the defendant's doctors."); *Davis v. Norris*, 423 F.3d 868, 885 (8th Cir. 2005) (Bye, J., concurring in part, dissenting in part) (stating that "psychological experts know the probative questions to ask of the opposing party's psychiatrists and how to interpret their answers" (internal quotation marks omitted));

In *Addington*, Burger further analogized involuntary civil commitment to denaturalization cases.<sup>102</sup> That comparison is also tenuous. The United States Attorney General's office can file a law suit to denaturalize persons who willfully misrepresented material facts on their naturalization applications; became members of a subversive group within five years of naturalization; or obtained naturalization through a relative, such as a spouse or parent, who had fraudulently obtained naturalization.<sup>103</sup> The due process standard of proof places the onus on the government to proffer clear and convincing evidence.<sup>104</sup> Whether the prosecution has presented a strong enough case is determined by evaluating the totality of the evidence.<sup>105</sup>

Denaturalization cases involve some element of fraud, misrepresentation, material error, or subversion.<sup>106</sup> None of these is applicable in involuntary commitment cases. As I present in detail in the next part of this Article, state laws allow for the forced internment of individuals in mental hospitals irrespective of any fault on their part. The closest analogy, and the one the *Addington* court rejected<sup>107</sup> and *Comstock* failed to address,<sup>108</sup> is to criminal cases.<sup>109</sup> Both are meant to prevent or

---

United States v. Perkins, 24 Fed. App'x 123, 124 (4th Cir. 2001) (per curiam) (holding that where there is conflicting mental health evidence about a defendant's competency to stand trial a court can weigh and evaluate which is more credible); *Bonin v. Calderon*, 59 F.3d 815, 832-33 (9th Cir. 1995) (reviewing opposing psychiatric evidence in the case of a serial sexual predator).

102. See *Addington*, 441 U.S. at 424 (discussing the standard of proof required in civil cases, specifically denaturalization cases).

103. See 8 U.S.C. § 1451 (2006) (detailing the revocation of naturalization).

104. See *Cooper v. Oklahoma*, 517 U.S. 348, 363 n.19 (1996) ("[D]ue process places a heightened burden of proof on the State . . .").

105. *Pullman-Standard v. Swint*, 456 U.S. 273, 284 n.14 (1982) ("A finding is 'clearly erroneous' when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed." (quoting *United States v. U.S. Gypsum Co.*, 333 U.S. 364, 395 (1948))).

106. 8 U.S.C. § 1451 (2006) (specifying that denaturalization is available if citizenship was "illegally procured or w[as] procured by concealment of a material fact or by willful misrepresentation").

107. See *Addington v. Texas*, 441 U.S. 418, 428 (1979) ("[A] civil commitment proceeding can in no sense be equated to a criminal prosecution.").

108. See generally *United States v. Comstock*, 130 S. Ct. 1949 (2010) (failing to discuss a parallel between criminal cases and civil commitments).

109. Some of the unique aspects of mental institutionalization may deprive some involuntary patients of even more liberties than incarceration, particularly in low security jails. Comparing the two deprivations of freedom, a circuit court found that involuntary civil commitment "may entail indefinite confinement, [which] could be a more intrusive exercise of state power than incarceration following a criminal conviction." *Project Release v.*



punish dangerous conduct. The denaturalization cases require no showing of danger, while involuntary commitment cases are meant to restrict the liberty of persons who are both dangerous and mentally ill.<sup>110</sup>

Involuntary commitments are most closely related to criminal punishments because both adjudicate whether respondents whom society has found to be too dangerous should be at liberty.<sup>111</sup> Both involve severe deprivations of liberty.<sup>112</sup> Without judicial oversight, the potential for abuse is enormous in both areas of law. The Court recognized that civil commitment, like imprisonment, "constitutes a significant deprivation of liberty that requires due process protection."<sup>113</sup> While Chief Justice Burger conceded that "lay jurors" can struggle differentiating between the intermediate scrutiny standard, he rejected the most cautious approach against false imprisonment.<sup>114</sup> Clarity on so consequential a matter as wrongly depriving a person from freely living and traveling is essential to procedural fairness.<sup>115</sup> Jurors are more likely to determine whether the prosecution has met its rigorous standard of proof by relying on the beyond

Prevost, 722 F.2d 960, 971 (2d Cir. 1983).

110. See *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975) ("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 . . . no constitutional basis for confining such persons involuntarily if they are dangerous to no one . . .").

111. A traditional purpose of criminal incarceration is to remove dangerous individuals from society at large. See, e.g., *Commonwealth v. Ritter*, 13 Pa. D. & C. 285, 291 (Pa. O. & T. 1930) ("To permit a man of dangerous criminal tendencies to be in a position where he can give indulgence to such propensities would be a folly which no community should . . . commit . . . . If . . . there is danger that a defendant may . . . commit crime, society should restrain his liberty until . . . danger be past . . ."). Similarly, there must be a component of dangerousness to justify civil commitment of an individual. See *O'Connor*, 422 U.S. at 575 (holding that a diagnosis of mental illness alone is not sufficient for civil commitment; individuals cannot be "involuntarily [committed] if they are dangerous to no one"). In discussing the constitutionality of civil commitments, the Supreme Court looked at the practice of incapacitation in the criminal law and noted the similar underlying goal of preventing repeat dangerous behavior. See *Foucha v. Louisiana*, 504 U.S. 71, 99 (1992) ("Incapacitation for the protection of society is not an unusual ground for incarceration. Isolation of the dangerous has always been considered an important function of the criminal law . . .").

112. See *Addington*, 441 U.S. at 425 ("[C]ivil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection.").

113. *Id.*

114. *Id.* at 424–25. Given the procedural complexity of these cases, the Court has recognized the right to counsel in involuntary commitment cases for prisoners being transferred to mental institutions. *Vitek v. Jones*, 445 U.S. 480, 496–97 (1980).

115. See *id.* (finding that due process protection is required as civilly committed individuals are deprived of substantial personal liberties).

a reasonable doubt evidentiary standard than the clear and convincing one.<sup>116</sup>

Subsequent to its holding in *Addington*, the Court has clarified and provided further guidance on the application of this intermediate standard.<sup>117</sup> *Foucha v. Louisiana* established that an "adversary hearing at which the State must prove by clear and convincing evidence that he is demonstrably dangerous to the community" was requisite to a civil commitment process.<sup>118</sup> While the Court reiterated that the individual's continued dangerousness and mental illness need not be proven beyond a reasonable doubt, it found that the right to be free from arbitrary bodily constraint was "at the core of the liberty protected by the Due Process Clause."<sup>119</sup> The Court also asserted that the need for clear and convincing review of involuntary confinement was based on the substantive fact that "[f]reedom from physical restraint" is "a fundamental right."<sup>120</sup> That finding, however, is difficult to reconcile with the Court's reliance on the intermediate standard for factual review given that fundamental rights are typically protected under the most stringent judicial scrutiny.

I think the only way to understand this inconsistency in ordinary cases involving fundamental rights and mental commitment cases is that the Court places greater credence in the testimony of mental health professionals than members of the criminal justice system. In criminal cases it is precisely because incarceration involves severe restraint on fundamental rights that the government is required to prove guilt beyond a reasonable doubt.<sup>121</sup> No conviction can be entered unless each element of an offence can be proven beyond a reasonable doubt.<sup>122</sup> In cases of persons

---

116. *Addington v. Texas*, 441 U.S. 418, 425 (1979) ("We probably can assume no more than that the difference between a preponderance of the evidence and proof beyond a reasonable doubt probably is better understood than either of them in relation to the intermediate standard of clear and convincing evidence.").

117. *See, e.g., Foucha v. Louisiana*, 504 U.S. 71, 80 (1992) (reiterating that a State may civilly commit "a mentally ill person if it shows by clear and convincing evidence that the individual is mentally ill and dangerous").

118. *Id.* at 81.

119. *Id.* at 80.

120. *Id.* at 86.

121. *See Chapman v. United States*, 500 U.S. 453, 465 (1991) ("Every person has a fundamental right to liberty in the sense that the Government may not punish him unless and until it proves his guilt beyond a reasonable doubt at a criminal trial conducted in accordance with the relevant constitutional guarantees.").

122. *See Alcorn v. Smith*, 781 F.2d 58, 64 (6th Cir. 1986) (remanding the petitioner's case because "he was convicted without proof of his guilt" and was entitled "to the fundamental right [of] proof of guilt beyond a reasonable doubt" before conviction).

purported to be mentally ill and dangerous, the fundamental interest in liberty is no less conspicuous.<sup>123</sup> The fact that mental illness is proven through far more pliable standards than the elements of a crime make stringent standards all the more important.<sup>124</sup> For that reason the state should carry a heavy burden before involuntarily interning a petitioner into a mental health facility.

The need for a beyond a reasonable doubt standard to prove danger and mental illness is further indicated by the possible abuse of due process even in the voluntary commitment context. In *Zinermon v. Burch*,<sup>125</sup> a former patient filed suit against physicians, administrators, and staff members at Florida State Hospital, for allowing him to sign a voluntary commitment form even though they should have been aware that he was too heavily medicated at the time of admission to make the decision.<sup>126</sup> The Court specifically indicated that a substantive due process right could have been raised in the case, even though petitioner had failed to do so in his filing.<sup>127</sup> Applying the procedural test from *Mathews v. Eldridge*,<sup>128</sup> as it

123. The Court has recognized in the context of criminally insane acquittees that "the State must have a particularly convincing reason" for involuntary commitment because "[f]reedom from physical restraint [is] a fundamental right." *Foucha v. Louisiana*, 504 U.S. 71, 85–86 (1992); *see also* *Youngberg v. Romeo*, 457 U.S. 307, 316 (1982) ("[L]iberty from bodily restraint always has been recognized as the core of the liberty protected by the Due Process Clause from arbitrary governmental action.").

124. Whereas in criminal cases every element of the offense must be proven beyond a reasonable doubt "[p]sychiatric diagnosis . . . is to a large extent based on medical 'impressions' drawn from subjective analysis and filtered through the experience of the diagnostician. This process often makes it very difficult for the expert physician to offer definite conclusions about any particular patient." *Addington v. Texas*, 441 U.S. 418, 430 (1979). Assessing a subject's mental condition and potential for present and future harm necessarily involves the subjective assessment of mental health. *Johnson v. Solomon*, 484 F. Supp. 278, 284 n.4 (D. Md. 1979).

125. *See Zinermon v. Burch*, 494 U.S. 113, 138–39 (1990) (holding that a patient, who was admitted on a voluntary basis to a state mental treatment facility by employees who failed to take any steps to ascertain whether he was mentally competent to sign admission forms, had standing to sue).

126. *Id.* at 118–21.

127. *See id.* at 126 ("[Petitioner]'s complaint could be read to include a substantive due process claim, but that issue was not raised in the petition for certiorari, and we express no view on whether the facts . . . allege[d] could give rise to such a claim.").

128. *See Mathews v. Eldridge*, 424 U.S. 319, 335 (1976) (outlining a test to be utilized in determining the amount of process due). Since its formulation in 1976, the Court's test in *Mathews v. Eldridge* has had a profound effect on cases across the gambit of civil litigation involving the deprivation of life and property. The test considers:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards;

had in *Addington*, the Court in *Zinermon* concluded that the petitioner had been deprived of procedural rights protecting individuals against unnecessary mental hospitalization.<sup>129</sup> That failure substantially deprived him of substantial liberty.<sup>130</sup>

#### IV. State Statutory Schemes

*Addington*'s adoption of the clear and convincing standard led to significant legal change in several states.<sup>131</sup> Before the ruling, civil commitment statutes in thirteen states and the District of Columbia required proof beyond a reasonable doubt, while twenty-five states required only a showing of clear and convincing evidence.<sup>132</sup> In response to the opinion, numerous states reduced their burdens of proof, making it easier to confine persons in mental institutions by diminishing the degree of judicial certainty needed to commit unwilling patients.<sup>133</sup> One can predict that *Comstock* will also loosen the rigor with which courts handle evidence in cases involving sex offenders and therefore increase the risk of erroneous confinement.

Few states currently have mental commitment statutes that are as rigorous as their criminal statutes.<sup>134</sup> Kentucky is one of those rare

---

and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

*Id.* at 335.

129. See *Zinermon*, 494 U.S. at 138 ("[A]ccording to the allegations of his complaint, [he] was deprived of a substantial liberty interest without either valid consent or an involuntary placement hearing, by the very state officials charged with the power to deprive mental patients of their liberty and the duty to implement procedural safeguards.").

130. See *id.* at 138–39 (finding that the failure to follow necessary procedure deprived the individual of liberty interests).

131. See *Addington v. Texas*, 441 U.S. 418, 433 (1979) (holding that a "clear and convincing standard . . . is required to meet due process guarantees").

132. See *supra* notes 73–75 (outlining differing state statutes).

133. Compare, e.g., *infra* notes 166–68 (discussing Oklahoma's reduced burden of proof post-*Addington*), with HAW. REV. STAT. § 334-60(b)(4)(I) (Supp. 1978) (requiring proof beyond a reasonable doubt for civil commitment) (repealed by Laws 1984, ch. 188, § 2), and HAW. REV. STAT. § 334-60.5 (2010) ("If the court finds that the criteria for involuntary hospitalization . . . has been met beyond a reasonable doubt and that the [other] criteria . . . have been met by clear and convincing evidence, the court may issue a[] [civil commitment] order . . .").

134. See, e.g., WASH. REV. CODE § 27-5-4 (J)(3) (2009) ("[F]indings of fact . . . must be based upon clear, cogent and convincing proof."); S.C. CODE § 44-17-580 (2009) ("If . . . the court finds upon clear and convincing evidence that the person is mentally ill [and] needs involuntary treatment . . . the court shall order . . . treatment at a mental health

exceptions.<sup>135</sup> A person can only be involuntarily hospitalized upon proof beyond a reasonable doubt that (1) he or she "presents a danger or threat of danger to self, family or others as a result of the mental illness;" (2) it is reasonably likely the person will benefit from treatment; and (3) hospitalization is the least restrictive means available for therapy.<sup>136</sup> Respondents are also guaranteed the right to a jury trial at which they can present and cross-examine witnesses.<sup>137</sup> This legislative scheme means that a person who is stable while on medications will not be forced into a hospital for unnecessary treatment.<sup>138</sup>

California courts likewise require proof beyond a reasonable doubt that the involuntary respondent is suffering from a mental disorder.<sup>139</sup> To confine a person involuntarily, the petitioning party must show that "no rational trier of fact could have failed to find" that the respondent "had serious difficulty controlling her dangerous behavior due to a mental disorder."<sup>140</sup> To some extent, due process interests are even more acute in civil commitment cases than in criminal proceedings because forced confinement to a mental institution, although subject to yearly review, may continue for a lifetime.<sup>141</sup>

Massachusetts's highest appellate court expressly recognized that it demands a more rigorous standard of proof than the threshold adopted in *Addington*.<sup>142</sup> Massachusetts states that relying on the beyond a reasonable

---

facility . . .").

135. See KY. REV. STAT. ANN. § 202A.076(2) (2009) ("The manner of proceeding and rules of evidence shall be the same as those in any criminal proceeding including the burden of proof beyond a reasonable doubt.").

136. KY. REV. STAT. ANN. § 202A.026 (2009); *id.* at § 202A.076.

137. *Id.*

138. See *Schuttemeyer v. Commonwealth*, 793 S.W.2d 124, 128 (Ky. Ct. App. 1990) (holding that a trial court wrongly decided involuntary commitment was necessary in the absence of sufficient evidence).

139. See *Ma v. David Y.*, 2007 WL 3173453, at \*5 (Cal. App. 2007) ("The evidence presented . . . is sufficient to support the judgment; it established beyond a reasonable doubt that David (1) had a mental disorder, and (2) that condition caused him to have serious difficulty controlling his behavior such that (3) he presented a substantial danger of physical harm to others.").

140. *In re Barbara B.*, 2007 WL 4374912, \*1 (Cal. Ct. App. Dec. 17, 2007).

141. See *Waltz v. Zumwalt*, 167 Cal. App. 3d 835, 837 (Cal. Ct. App. 1985) ("[Involuntary] confinement may continue for a year with the possibility of additional year-long extensions, perhaps for the rest of [the individual's] life. . . . It is no less incarceration because it is called civil.").

142. See *Aime v. Commonwealth*, 611 N.E.2d 204, 213 n.18 (Mass. 1993) ("[W]e require . . . [proof] beyond a reasonable doubt that the release of a mentally ill person would create a substantial risk of physical harm to others as a predicate to involuntary commitment

doubt standard is not an empty procedural device but an indication of the highest regard society places on individual liberty.<sup>143</sup> Although those proceedings are civil, the Massachusetts Supreme Court found that the beyond a reasonable doubt standard was needed because they pit the interests of individuals against those of the state,<sup>144</sup> which is structurally indistinguishable from criminal proceedings.<sup>145</sup>

The United States Court of Appeals for the District of Columbia has not revisited the issue since the Supreme Court's 1979 ruling in *Addington*.<sup>146</sup> The District of Columbia Circuit Court has nevertheless understood the Supreme Court's opinion to diminish petitioners' required burden of proof.<sup>147</sup> The lower courts follow the change in the District of Columbia's Code,<sup>148</sup> which explicitly requires only a clear and convincing showing of proof.<sup>149</sup>

The mental health codes in Rhode Island, Hawaii, and Montana are more nuanced. Rhode Island's mental health statute handles forced institutionalization very much along the lines of a criminal proceeding: notice must be provided, a probable cause hearing must be held shortly after initial patient intake, the right to a speedy hearing is guaranteed, and

of such person. . . . [T]he United States Supreme Court permits the States to use the . . . clear and convincing evidence standard.").

143. See *In re Andrews*, 870 N.E.2d 610, 615 (Mass. 2007) (determining the applicable standard of proof "is not an empty semantic exercise; it reflects the value society places on individual liberty"); *Matter of Guardianship of Roe*, 421 N.E.2d 40, 45 (Mass. 1981) (evaluating the standard of proof that should be required).

144. See *Petition of Dep't of Soc. Servs. to Dispense with Consent to Adoption*, 467 N.E.2d 861, 864 (Mass. 1984) (discussing generally instances in which the highest standard of proof is required in civil proceedings).

145. See Barbara D. Underwood, *The Thumb on the Scales of Justice: Burdens of Persuasion in Criminal Cases*, 86 YALE L.J. 1299, 1308 (1977) ("[T]he . . . function of the reasonable doubt rule . . . [is to] protect[] individuals against the state's power to convict, by giving the accused in a criminal case a generous benefit of the doubt.").

146. See *In re Ballay*, 482 F.2d 648, 650 (D.C. Cir. 1973) (holding that given the interest involved in civil commitment, the most stringent burden of proof is required because it involves a loss of liberty similar to criminal process).

147. See *In re Perruso*, 896 A.2d 255, 259 (D.C. 2006) (holding that outpatient status should only be revoked where clear and convincing evidence exists of potential injury and mental illness); *In re Artis*, 615 A.2d 1148, 1151 (D.C. 1992) (deciding that the factfinder's role at trial is to determine whether clear and convincing evidence indicates mental illness and likelihood of self-inflicted injury).

148. See, e.g., *Foucha v. Louisiana*, 504 U.S. 71, 80 (1992) (reiterating that a State may civilly commit "a mentally ill person if it shows by clear and convincing evidence that the individual is mentally ill and dangerous").

149. See D.C. CODE § 21-548 (1981) (stating that commitment is allowed "based upon clear and convincing evidence").

certificates of psychiatric examinations must be tendered at the hearing.<sup>150</sup> The Supreme Court of Rhode Island has interpreted the mental health law to require the state to demonstrate proof beyond a reasonable doubt before a judge can issue a certificate authorizing the original commitment, and "clear and convincing evidence supporting identical findings" for recertifying an unwilling patient.<sup>151</sup>

Hawaii requires proof beyond a reasonable doubt for the institutionalization when a "person is imminently dangerous to self or others, is gravely disabled or is obviously ill"<sup>152</sup> or proof of clear and convincing evidence for persons in need of treatment where there is no less restrictive alternative to coerced treatment.<sup>153</sup> The Hawaii statute applies to a much wider group than the Supreme Court envisioned in *Addington*: It applies to persons diagnosed as having both mental illness and those addicted to illicit substances.<sup>154</sup> This striking feature of the Hawaii statute groups substance abusers, who are typically punished under state criminal statutes, with the mentally ill.<sup>155</sup>

Montana demonstrates the greatest sensitivity to the various phases of the commitment process. It sets out a variety of evidentiary schemes designed to avoid unnecessary institutionalization.<sup>156</sup> Proof is required beyond a reasonable doubt as to all medical facts or evidence, "and [by] clear and convincing evidence as to all other matters."<sup>157</sup> Petitioner must prove the "mental disorder" diagnosis "to a reasonable medical certainty."<sup>158</sup> Even proof of dangerousness is defined quite tightly to prevent overzealous prosecution and erroneous adjudication.<sup>159</sup>

150. R.I. GEN. LAWS § 40.1-5-8 (2009).

151. *In re Doe*, 440 A.2d 712, 714 (R.I. 1982).

152. HAW. REV. STAT. § 334-60.2(2), 334-60.5(i) (2010).

153. *See id.* § 334-60.2(3), 334-60.5(i) (requiring that "there [be] no suitable alternative available through existing facilities and programs which would be less restrictive than hospitalization").

154. *See id.* § 334-60.2(1) ("A person may be committed to a psychiatric facility for involuntary hospitalization, if the court finds: (1) That the person is mentally ill or suffering from substance abuse.").

155. *Id.*

156. *See generally* MONT. CODE ANN. § 53-21-126 (2005) (specifying the applicable standards of proof and what factors the trial court should consider in determining the necessity of institutionalization).

157. *Id.* § 53-21-126(2).

158. *Id.*

159. *See id.* ("Imminent threat of self-inflicted injury or injury to others must be proved by overt acts or omissions, sufficiently recent in time as to be material and relevant as to the respondent's present condition.").

The overwhelming majority of states do not use the highest standard of proof for involuntary institutionalization hearings.<sup>160</sup> They instead rely on the Supreme Court's holding in *Addington*, which only requires clear and convincing proof.<sup>161</sup> That precedent, which the Court recently reconfirmed in *Comstock*, downplayed the risk of erroneous deprivation by noting that involuntary commitments require family involvement and "layers of professional review."<sup>162</sup> First, it is unclear whether the layers of professional evaluations will be sufficient given the for-profit nature of mental health, which I will discuss in Part VI. Second, involuntary commitment decisions are often not professionally layered but made by one psychiatrist, psychologist, or even a psychiatric nurse.<sup>163</sup> Finally, family involvement occurs at the criminal level as well, but family members' opinions have never been regarded to be substitutes for careful judicial assessment in criminal cases.<sup>164</sup> Many reported civil commitment cases indicate that, contrary to the Supreme Court's assumption, family members sometimes seek forced commitment as a type of vendetta rather than out of any real concern for the involuntary patients' mental health or safety.<sup>165</sup>

---

160. See *supra* note 134 and accompanying text (providing examples of state statutes requiring a lower standard of proof than the beyond a reasonable doubt standard).

161. See *Addington v. Texas*, 441 U.S. 418, 433 (1979) (holding that only a "clear and convincing standard [of proof] . . . is required to meet due process guarantees").

162. See *id.* at 433 (holding that only a "clear and convincing standard [of proof] . . . is required to meet due process guarantees").

163. See *supra* note 16 and accompanying text (discussing the professionals whose determinations are sufficient to civilly commit an individual).

164. See generally Darryl K. Brown, *Third-Party Interests in Criminal Law*, 80 TEX. L. REV. 1383 (2002) (discussing the impact of the defendant's family throughout the criminal proceeding).

165. See, e.g., Kym Klass, *Upset Sister Put Montgomery Woman in Mental Institution*, MONTGOMERY ADVERT. (Montgomery, Ala.), Dec. 29, 2009 (discussing a case where a sister filed a petition to institutionalize her sister because of sibling rivalry). Besides outright vendettas, there are multiple cases where family members disagree about whether one of them needs to be civilly committed. See, e.g., *In the matter of the Commitment of K.F. v. St. Vincent Hosp. & Health Care Ctr.*, 909 N.E.2d 1063, 1067 (Ind. Ct. App. 2009) ("Two of K.F.'s daughters opined that she could not function independently. Yet, K.F.'s husband and son disagreed . . ."). A civil commitment justice in Virginia relayed an actual case: "A psychiatrist regularly commits a child for periodic stays in a mental hospital when his mentally-ill mother, a patient of the psychiatrist, needs a respite period from her child. Although the child has no mental illness, the psychiatrist creates a diagnosis for purposes of admission." Richard E. Redding, *Children's Competence to Provide Informed Consent for Mental Health Treatment*, 50 WASH. & LEE L. REV. 695, 701 (1993). For a detailed discussion of juvenile commitments under questionable family circumstances, see Alexander Tsesis, *Protecting Children Against Unnecessary Institutionalization*, 39 S. TEX. L. REV. 995, 1009-17 (1998).



Prior to the Supreme Court's decision in *Addington*, the Oklahoma statute required proof beyond a reasonable doubt, but after the decision the state's statute was revoked in favor of the milder clear and convincing prosecutorial burden.<sup>166</sup> Before the statutory repeal, the state's highest court explained the reasoning behind the test: "Involuntary commitment to a mental hospital involves a massive curtailment of an individual's liberty, and in many ways resembles a criminal arrest because the individual is taken into custody by the police and, eventually, involuntarily confined in a state institution."<sup>167</sup> Subsequent to the ruling in *Addington*, the legislature repealed the mental health statute's requirement for proof beyond a reasonable doubt.<sup>168</sup>

Other states that formerly used the highest standard of proof also have explicitly shifted to the middle level of judicial evaluation. An Idaho statute, for example, requires clear and convincing evidence that the patient is mentally ill, poses a threat to himself or others or is gravely mentally ill, and lacks the ability to make an informed consent.<sup>169</sup> A hearing on the petition to involuntarily institutionalize needs to be held no later than five days after being filed with a court.<sup>170</sup> Without the most rigorous judicial evaluation of the evidence, it appears there is tremendous potential for abuse of the emergency confinement because a petition can be initiated by "a friend, relative, spouse or guardian of the proposed patient, or by a licensed physician, prosecuting attorney, or other public official of a municipality."<sup>171</sup> Allowing personal acquaintances to initiate hearings

---

166. See *B.J.B. v. Dist. Court of Okla. Cty.*, 611 P.2d 249, 250 (Okla. 1980) (quoting and applying the previous statutory provision of OKLA. STAT. tit. 43A, § 54.1(c)).

167. See *In re D.B.W.*, 616 P.2d 1149, 1152 (Okla. 1980) (justifying procedural safeguards prior to an involuntary commitment).

168. See OKLA. STAT. ANN. tit. 43A, § 54.1(c) (1979) ("The court, at the hearing on the petition, shall determine, beyond a reasonable doubt, if the person is a person requiring treatment."), repealed by 1980 Okla. Sess. Laws 935 (codified at OKLA. STAT. ANN. tit. 43A § 5-410 (2006)).

169. See IDAHO CODE ANN. § 66-329(11) (2009) ("If . . . the court finds by clear and convincing evidence that the proposed patient: (a) Is mentally ill; and (b) Is, because of such condition, likely to injure himself or others, or is gravely disabled due to mental illness; the court shall order the proposed patient committed . . .").

170. See *id.* § 66-329(4)-(6) (requiring a court to appoint designated examiners within forty eight hours, then receive a report within seventy two hours, and then schedule a hearing for a time within seven days, giving the court a maximum of twelve days before a hearing must be held).

171. IDAHO CODE ANN. § 66-329(1) (2009). An Alaska statute has a similar provision allowing "any adult" to file a petition to the court for an ex parte hearing to institutionalize a person involuntarily. ALASKA STAT. § 47.30.700(a) (2006); see James B. Gottstein, *Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights*

that can lead to severe deprivation of liberty leaves opportunity for abuse, mistake, or malice, which the beyond a reasonable doubt standard can more readily prevent.<sup>172</sup> A further problem with the Idaho statute is that it allows judges even more latitude than the Supreme Court stated was constitutional in *Foucha v. Louisiana*, which required proof of both danger and mental illness, while Idaho allows for grave mental illness to be proven instead of danger.<sup>173</sup>

Some other states have also lowered the burden on the party seeking to institutionalize a patient, settling for the floor established in *Addington*.<sup>174</sup> Other states that currently rely on the intermediate standard of proof had it in place prior to the *Addington* ruling.<sup>175</sup> Washington and West Virginia use a slightly modified version, providing that a trier of facts in civil commitment hearings rely only on "clear, cogent and convincing evidence."<sup>176</sup>

---

*Violations as a Matter of Course*, 25 ALASKA L. REV. 51, 72–73 (2008) (providing anecdotal information about Anchorage, Alaska judges' routine granting of ex parte orders without careful scrutiny of the evidence). In that state, a police officer, physician, psychiatrist, or psychologist can have a party immediately taken into custody and placed in a hospital without any judicial involvement. § 47.30.705(a) (2006).

172. See William H. Abrashkin, Comment, *The Standard of Proof in Civil Commitment Proceedings in Massachusetts*: Superintendent of Worcester State Hospital v. Hagberg, 1 W. NEW ENG. L. REV. 71, 85–86 (1978) (arguing that the beyond a reasonable doubt standard helps to avoid erroneous and unjust commitments).

173. See *Foucha v. Louisiana*, 504 U.S. 71, 80 (observing that case law requires a showing of both danger and mental illness before an individual may be involuntarily committed); IDAHO CODE ANN. § 66-329(2)(11)(b) (2009) (requiring a showing of clear and convincing evidence that a proposed patient is either a danger or gravely mentally ill before a court may order civil commitment).

174. See, e.g., KAN. STAT. ANN. § 59-2917 (1979) ("Upon completion of the hearing, if the court or jury finds that the proposed patient is beyond a reasonable doubt a mentally ill person, and after a careful consideration of reasonable alternatives to inpatient treatment the court shall order treatment for such person at any treatment facility."), *repealed by* 1996 Kan. Sess. Laws, ch. 167, § 65; OKLA. STAT. tit. 43A, § 54.1(c) (1979) ("The court, at the hearing on the petition, shall determine, beyond a reasonable doubt, if the person is a person requiring treatment."), *repealed by* 1980 Okla. Sess. Laws, c. 324, § 13; UTAH CODE ANN. § 64-7-36.6 (1977) (using a beyond a reasonable doubt standard for civil commitments), *repealed by* 1989 Utah Laws, c. 22, § 51.

175. See *supra* note 75 and accompanying text (listing the states that had the intermediate standard of proof before *Addington*).

176. See WASH. REV. CODE § 27-5-4 (J)(3) (2009) ("The findings of fact shall be incorporated into the order entered by the circuit court and must be based upon clear, cogent and convincing proof."); *In the Matter of Ernest McLaughlin*, 676 P.2d 444, 451 (Wash. 1994) ("The burden of proof, at a 90-day involuntary commitment proceeding, is proof by clear, cogent and convincing evidence."); *Pifer v. Pifer*, 273 S.E.2d 69, 71 (W. Va. 1980) (stating that the burden of proof for involuntary commitments is clear, cogent and

V. *Comstock and State Sexual Violent Predator Statutes*

In *Comstock*, the Supreme Court imported the burden of proof standard from its earlier civil commitment holding in *Addington* into the post-criminal conviction context.<sup>177</sup> Some states, such as Minnesota, already use the clear and convincing standard for the civil commitment of sexually dangerous persons.<sup>178</sup> Other states rely on more rigorous standards, and it is those states that might now have reason to rely on *Comstock* to loosen their sexual predator commitment proceedings.<sup>179</sup> By unquestioningly accepting the intermediate standard of evidentiary scrutiny, the Court provided states with a way of easing prosecutorial efforts to civilly commit a politically unpopular group.<sup>180</sup>

States like Arizona, which currently require a beyond a reasonable doubt showing to prove that a person named in a petition is sexually violent,<sup>181</sup> might choose to diminish the stringency of review for inculpatory sexual predator evidence. *Comstock* has the same potential to affect policy in Illinois where the Sexually Dangerous Persons Act relies on hearings that

---

convincing evidence).

177. See *United States v. Comstock*, 130 S. Ct. 1949, 1965 (2010) ("The Constitution . . . authorizes Congress to enact the statute."). The much discussed issue of whether it is double jeopardy to civilly commit sexually violent predators after the expiration of their term of imprisonment is beyond the scope of this article. See *Kansas v. Hendricks*, 521 U.S. 346, 361 (1997) (stating that post-conviction civil commitment of sexually violent predators does not constitute double jeopardy). I am concerned in this Article with due process concerns that bridge the inadequacy of evidentiary proof both for persons subject to civil commitment who have not been convicted for any previous offense and those who are in the post-conviction stage.

178. See MINN. STAT. § 253B.185(1) (2007) ("[T]he court shall commit the [sexually dangerous person] to a secure treatment facility unless the patient establishes by clear and convincing evidence that a less restrictive treatment program is available that is consistent with the patient's treatment needs and the requirements of public safety.>").

179. See CAL. WELF. & INST. CODE § 6604 (West 2006) ("The court or jury shall determine whether, beyond a reasonable doubt, the person is a sexually violent predator."); KAN. STAT. ANN. § 59-29a07(a) (2006) ("The court or jury shall determine whether, beyond a reasonable doubt, the person is a sexually violent predator."); WIS. STAT. § 980.05(3)(a) (2005) ("At a trial on a petition under this chapter, petitioner has the burden of proving beyond a reasonable doubt that the person who is the subject of the petition is a sexually violent person."); ARIZ. REV. STAT. ANN. § 36-3707(A) (1998) ("The court or jury shall determine beyond a reasonable doubt if the person named in the petition is a sexually violent person.>").

180. See *Comstock*, 130 S. Ct. at 1953 ("The Court does not reach or decide any claim that the statute or its application denies equal protection, procedural or substantive due process, or any other constitutional rights.>").

181. See ARIZ. REV. STAT. § 36-3707(A) (1998) ("The court or jury shall determine beyond a reasonable doubt if the person named in the petition is a sexually violent person.>").

are "civil in nature" but require proof beyond a reasonable doubt.<sup>182</sup> Some states, like California, which purport to use the beyond a reasonable doubt standard for sexual violent predator (SVP) commitments in fact are more nuanced than they first appear.<sup>183</sup> In California, a person convicted of a sexually violent offense can be declared a SVP after a jury trial finds "beyond a reasonable doubt that the person suffers from a diagnosed mental disorder that makes them a danger to the health and safety of others in that it is likely that he or she will engage in sexually violent criminal behavior."<sup>184</sup> However, dangerousness is determined by assessing whether the respondent is "likely to engage in acts of sexual violence,"<sup>185</sup> which "does not require a precise determination that the chance of reoffense is better than even."<sup>186</sup> That means that even the testimony of two mental health professionals that there is a 45% chance that a past sexual criminal offender remains unable to restrain anti-social sexual behavior will likely be sufficient to trigger civil commitment.<sup>187</sup> Following *Comstock*, California

---

182. See 725 ILL. COMP. STAT. 205/3.01 (2010) ("The proceedings under this Act shall be civil in nature, however, the burden of proof required to commit a defendant to confinement as a sexually dangerous person shall be the standard of proof required in a criminal proceedings of proof beyond a reasonable doubt."). The testimony of two court appointed psychiatrists is required to ascertain whether the respondent is sexually dangerous. See *id.* at 205/4 ("[T]he court shall appoint two qualified psychiatrists to make a personal examination of such alleged sexually dangerous person, to ascertain whether such person is sexually dangerous . . ."). Persons can be convicted under the Act even without ever having been convicted for a sexual offense. See *Varner v. Monohan*, 460 F.3d 861, 865 (7th Cir. 2006) ("In addition to the SVPA, which applies to people such as Varner who have criminal records, Illinois has [legislation] . . . which authorizes the indefinite civil confinement of persons who have yet to be convicted of sex offenses but are deemed likely to endanger others."). It may be argued that *Comstock* is inapplicable under these circumstances because that case dealt with post-sentencing civil commitment or "clear and convincing evidence that the person committed a sex crime for which he was never charged." *Comstock*, 130 S. Ct. at 1977 n.9. I think that would be incorrect. Whether civil commitment is based on a previous conviction or not, the question is whether a person poses a social danger at the time of the hearing.

183. See *infra* notes 184–87 and accompanying text (showing that California's SVP statute is more complex than it appears).

184. *Garcetti v. Superior Court*, 102 Cal. Rptr. 2d 214, 218 (Cal. Ct. App. 2000).

185. See *People v. Ghilotti*, 44 P.3d 949, 972 (quoting CAL. WELF. & INST. CODE § 6601(d) (West 2008)) (discussing how evaluators' pre-hearing findings are determined).

186. See *id.* (discussing how evaluators' pre-hearing findings are determined).

187. *Id.* In an e-mail, Professor Christopher Slobogin, a mental health law specialist, points out: "Quantitatively, that means that in this purportedly BRD state the government need merely show a possibility of danger: .95 (BRD) x .45 (the Ghilotti standard) = .42." E-mail from Christopher Slobogin, Milton Underwood Chair in Law and Professor of Psychiatry, Vanderbilt University, to Alexander Tsesis, Assistant Professor of Law, Loyola School of Law (June 25, 2010) (on file with author). Such a standard appears to be no more

can choose to relax its modified beyond a reasonable doubt standard further and thereby make it easier to commit people with no certainty that they require forced deprivation of liberty.

Other states will now be able to relax existing portions of their SVP statutes that have various criminal components. Florida combines criminal with civil norms, permitting SVPs to be committed only upon a jury's unanimous finding based on clear and convincing evidence.<sup>188</sup> *Comstock* contains no jury requirement.<sup>189</sup> Florida courts routinely use psychologists' testimony to evaluate whether the sex offender continues to pose a risk of harm.<sup>190</sup> This provides professional judgments for factfinders in civil commitment cases.<sup>191</sup> The availability of such testimony does not, as I will demonstrate in the next section, assure objectivity, and must be checked against exacting legal checks on veracity to prevent unnecessary confinement. One Florida court of appeals pointed out the existing debates among clinicians about what actuarial approaches provide accurate risk assessments: "Unfortunately, the existing actuarial tools do not seem to address all relevant static risk factors. 'Given the current knowledge, sexual predator laws will lead to some individuals being detained who would not offend, and a number of individuals will be released who will reoffend.'"<sup>192</sup> The beyond a reasonable doubt standard would be the most cautious way for juries to assess whether the facts compel

---

than an end-run around the double jeopardy prohibition, but California courts have turned aside that claim because they consider SVP commitments to be therapeutic rather than punitive in nature. *See* *Hubbart v. Superior Court*, 969 P.2d 584, 603, 607 (Cal. 1999) (characterizing the conditions of the civil commitment of a SVP as therapeutic); *People v. Carlin*, 58 Cal. Rptr. 3d 495, 515–16 (Cal. Ct. App. 2007) (dismissing a challenge that the civil commitment of a SVP on the grounds of double jeopardy principles because the goal was treatment rather than punishment).

188. *See* FLA. STAT. ANN. § 394.917(1) (West 2004) ("The court or jury shall determine by clear and convincing evidence whether the person is a sexually violent predator. If the determination is made by a jury, the verdict must be unanimous.").

189. *See generally* *United States v. Comstock*, 130 S. Ct. 1949 (2010) (lacking a jury requirement).

190. *See, e.g.,* *Hawker v. State*, 951 So.2d 945, 947 (Fla. Dist. Ct. App. 2007) (describing a psychologist's testimony); *Houtsma v. State*, 828 So.2d 1035, 1036 (Fla. Dist. Ct. App. 2002) (describing psychologists' testimony and using it as determinative evidence in upholding a lower court).

191. *See* FLA. STAT. ANN. § 394.916(4) (2006) ("If the person is subjected to a mental health examination under this part, the person may also retain experts or mental health professionals to perform an examination [for use as a professional witness at trial].").

192. *Lee v. State*, 854 So.2d 709, 718 (Fla. Dist. Ct. App. 2003) (quoting Judith V. Becker & William D. Murphy, *What We Know and Do Not Know About Assessing and Treating Sex Offenders*, 4 PSYCHOL. PUB. POL'Y & L. 116, 127 (1998)).

institutionalization, but that degree of scrutiny is not required under *Comstock*.

*Comstock* was unclear whether the clear and convincing standard is the floor for due process,<sup>193</sup> but it can be argued that without at least that minimum threshold SVP statutes do not even meet the *Addington* standard. One example of a law that appears to fail constitutional muster is the SVP statute in Iowa. That statute deals with SVP civil commitment hearings at the post sentencing phase, which was the subject addressed in *Comstock*.<sup>194</sup> But in Iowa all that is required is a finding of probable cause.<sup>195</sup> That means the prosecution needs merely to show that it is "more likely than not" that the SVP will reoffend.<sup>196</sup> Such a standard is so lax that it allows virtually any rationale to suffice for forced deprivation of liberty.

Because *Comstock* was decided just last year it is impossible to precisely predict whether its reliance on the clear and convincing standard will become the threshold burden for sexual predator statutes.<sup>197</sup> Most likely, it at least signals to states with beyond a reasonable doubt standards that a lower threshold of proof is constitutional and that the preponderance of the evidence standard is insufficient. Given the ambiguity of danger and mental illness assessments, even the clear and convincing evidence standard is insufficient to guard respondents' due process rights.

## VI. Psychiatric Ambiguities

The ambiguities of the two criteria the Supreme Court relied on in *Comstock* for involuntary institutionalization—dangerousness and mental

---

193. See *Comstock*, 130 S. Ct. at 1956 ("[W]e assume, but do not decide, that other provisions of the Constitution—such as the Due Process Clause—do not prohibit civil commitment in these circumstances.").

194. See IOWA CODE § 229A.4 (1999) ("If it appears that a person presently confined may be a sexually violent predator . . . the attorney general may file a petition alleging that the person is a sexually violent predator . . .").

195. See IOWA CODE § 229A.5(2) ("[A] hearing shall be held to determine whether probable cause exists to believe the detained person is a sexually violent predator."); *In re Detention of Hennings*, 744 N.W.2d 333, 335 (Iowa 2008) (discussing Iowa's SVP civil commitment provisions).

196. IOWA CODE § 229A.2(4) (2005).

197. See generally *United States v. Comstock*, 130 S. Ct. 1949 (2010) (providing the date of decision).

illness<sup>198</sup>—are well documented in the psychiatric literature.<sup>199</sup> In the seminal case creating the clear and convincing standard for civil commitment hearings, *Addington*, the Court explicitly recognized the "the lack of certainty and the fallibility of psychiatric diagnosis."<sup>200</sup> Despite the significant risk of error, the Court decided not to increase the burden of proof to beyond a reasonable doubt, explaining that if it were to do so, "there is a serious question as to whether a state could ever prove beyond a reasonable doubt that an individual is both mentally ill and likely to be dangerous."<sup>201</sup> That unexpected result allowed the pragmatics of trial practice to outweigh the due process rights of unwilling respondents. It's impossible to imagine the Court comparably saying that because the scienter element is so difficult to prove in criminal prosecutions the burden of proof should be less than beyond a reasonable doubt.

One of the Court's untested assumptions is that the psychiatric community is on the whole disinterested and objective.<sup>202</sup> At present, no techniques comparable to x-rays, CAT scans, or blood tests exist, so that diagnoses are entirely on nonverifiable and controversial criteria.<sup>203</sup> Psychiatric diagnoses are not simply descriptive but value laden in their assessment of patients' emotional and mental conditions.<sup>204</sup> The Court was

198. *See id.* at 1960 (noting that the congressional statute at issue requires a showing of dangerousness and mental illness). In his dissent to the case, Justice Thomas disagrees about the majority's holding on congressional use of its Necessary and Proper powers, but he finds no disagreement about the bilateral standard for involuntary commitment. *Id.* at 1974 (Thomas, J., dissenting).

199. *See supra* notes 24–34 and accompanying text (showing that psychiatric literature regards both dangerousness and mental illness as ambiguous criteria).

200. *Addington v. Texas*, 441 U.S. 418, 429 (1979).

201. *Id.* Several authors have accepted the Court's reasoning without analyzing whether the lack of diagnostic certainty in psychiatry might require additional rather than diminished protections against due process violations. *See, e.g.*, E. Lea Johnston, *An Administrative "Death Sentence" for Asylum Seekers: Deprivation of Due Process Under 8 U.S.C. § 1158(D)(6)'s Frivolousness Standard*, 82 WASH. L. REV. 831, 875–76 (2007) (agreeing with the *Addington* Court's decision that the beyond a reasonable doubt standard was too rigorous); Justin Engel, Comment, *Constitutional Limitations on the Expansion of Involuntary Civil Commitment for Violent and Dangerous Offenders*, 8 U. PA. J. CONST. L. 841, 863 (2006) (accepting the *Addington* Court's reasoning).

202. *Cf. Addington*, 441 U.S. at 430 ("The subtleties and nuances of psychiatric diagnosis render certainties virtually beyond reach in most situations.").

203. *See id.* ("Psychiatric diagnosis . . . is to a large extent based on medical 'impressions' drawn from subjective analysis and filtered through the experience of the diagnostician.").

204. *See* Abraham Rudnick, *Ethical Implications of Emotional Impairment*, in *FACT AND VALUE IN EMOTION* 87, 88–89 (Louis C. Charland & Peter Zachar eds., 2008) (discussing the intrinsic moral values at play in the evaluation of individuals' competence to

either unaware or ignored the ongoing debate about whether non-neurologically based mental illness even exists.<sup>205</sup> The very existence of that disagreement seems to point to a very rigorous level of proof before forced hospitalization is warranted.

There are also contrasting views among mainstream psychiatrists and psychologists. Mental assessments are often contradictory, requiring judicial evaluation, cross examination, and impeachment to determine their validity.<sup>206</sup> Unlike other physicians, psychiatrists typically operate on the basis of impressions rather than physical diagnoses, making it difficult for them "to offer definite conclusions about any particular patient."<sup>207</sup> Under

---

freely decide on whether treatment was appropriate). In his book on erroneous psychiatric classifications of deviance as psychiatric disorders, Nicholas N. Kittrie gives examples of "some of history's most illustrious figures" whose mental states might have been classified as insane delusions: "Hegel, the philosopher, believed himself a god; Saul, the first Israelite king, suffered from extreme depression; Martin Luther thought himself under attack from tangible devils; Goethe and Dante entertained irrational dislikes of their mother countries; and Mozart believed that the Italians were planning to poison him." NICHOLAS N. KITTRIE, *THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY* 52 (1971).

205. Contrast the view of Edward Shorter and Thomas Szasz. Shorter believes that the major mental illnesses [e.g., schizophrenia] have always been with "us" and "the minor ones, such as anxiety, neurotic depression, and obsessive-compulsive behavior have accompanied mankind as well." EDWARD SHORTER, *A HISTORY OF PSYCHIATRY: FROM THE ERA OF THE ASYLUM TO THE AGE OF PROZAC* 22 (1997). Szasz, on the other hand, has long written that mental illness is a myth used to establish cultural control and professional, psychiatric authority:

What is . . . *the thing itself* that psychiatrists describe, debate, diagnose and treat? The psychiatrist says it is *mental illness*, which, he now quickly adds, is the name of the *neurochemical lesions* of the brain. I say it is conflict and coercion and the rules that regulate the psychiatrist's powers and privileges and the patient's rights and responsibilities. The former perspective leads to an analysis of psychiatry in terms of illness and treatment, medical theory and therapeutic practice, while the latter perspective leads to an analysis in terms of coercion and contract, the exercise of power and the efforts to limit it, in short, political theory and legal practice.

THOMAS SZASZ, *INSANITY: THE IDEA AND ITS CONSEQUENCES* xiii (1997).

206. In *Barefoot v. Estelle*, the Supreme Court acknowledged that the petitioner and an amicus, American Psychiatric Association, presented research to demonstrate that psychiatrists' predictions of patients' future dangerousness were usually wrong. *Barefoot v. Estelle*, 463 U.S. 880, 900–01 (1983), *superseded on other grounds by* 28 U.S.C. § 2253(c)(2) (2006). But the Court held that criminal procedural devices like cross examination and impeachment are enough to protect the defendant's constitutional rights. *Id.* at 898–99; *see also* *Gonzales v. Tafoya*, 515 F.3d 1097, 1113 (10th Cir. 2008) (stating that "the judge is required to evaluate contrasting testimony from mental health professionals, and in that way his task resembles that of the judge in adult civil commitment proceedings").

207. *Addington v. Texas*, 441 U.S. 418, 430 (1979).



these circumstances, the best means of protecting individual rights against false positive mental illness diagnoses is to demand proof beyond a reasonable doubt of the party petitioning the court for an order of civil commitment. The use of the clear and convincing standard diminishes the protections available to individuals in favor of judicial and prosecutorial efficiencies.<sup>208</sup>

The civil commitment process often begins in emergency rooms when family members or police officers arrive with a potential patient, and it is there that healthy people are at the greatest risk of being unnecessarily committed.<sup>209</sup> While at this point in admission the beyond a reasonable doubt standard would be too much to demand (just as with criminal arrests all that can be expected short of eliminating civil commitment is probable cause), diagnostic limitations raise standard of proof issues for post-emergency placement hearings. A review of 939 inpatient admissions in emergency settings discovered that initial screenings are extremely unreliable.<sup>210</sup> A study found that by the time of discharge there was a 38.7% rate of change in diagnoses, demonstrating that the initial reasons for involuntary hospitalizations were spurious.<sup>211</sup> This study might have gone further to determine not only the rate of misdiagnoses but also the proportion of committed persons for whom internment was completely unnecessary.

The social concern for safety is reflected in the dangerousness component of the involuntary institutionalization test.<sup>212</sup> A state can only confine mentally ill persons who have demonstrated a propensity for

---

208. *People v. Superior Court*, 196 Cal Rptr. 431, 436 (Cal Ct. App. 1983) (interpreting the *Addington* decision to mean that "[t]he fact that psychiatric predictions are imprecise does not, however, prevent society from protecting itself from those who are dangerously mentally ill").

209. See Cristina Marta Del-Ben et al., *Accuracy of Psychiatric Diagnosis Performed Under Indirect Supervision*, 27 REVISTA BRASILEIRA DE PSIQUIATRIA 58, 60 (2005), available at [http://www.scielo.br/scielo.php?pid=S1516-44462005000100013&script=sci\\_arttext](http://www.scielo.br/scielo.php?pid=S1516-44462005000100013&script=sci_arttext) (reporting that psychiatric diagnoses are least reliable when predicated on hospital admission and outpatient interviews).

210. See *infra* note 211 and accompanying text (describing the study).

211. See Benjamin K.P. Woo et al., *Factors Influencing the Stability of Psychiatric Diagnoses in the Emergency Setting*, 28 GEN. HOSP. PSYCHIATRY 434, 435 (2006) ("Overall, our finding suggested that a sizable portion (38.7%) of psychiatric emergency patients were given a different diagnosis at time of discharge from the inpatient service.").

212. See *Addington v. Texas*, 442 U.S. 418, 426 ("[T]he state . . . also has authority under its police powers to protect the community from the dangerous tendencies of some who are mentally ill.").

dangerous conduct.<sup>213</sup> If mental illness is difficult to prove, the dangerousness element is even more difficult because it involves a prediction of future behavior.<sup>214</sup> Whereas a diagnosis of mental illness can be predicated on evaluations of the patients' existing condition, mental health professionals' evaluations of dangerousness include prognostic findings that are more problematic.<sup>215</sup> Clinicians who testify at involuntary hospitalization hearings are asked to provide clear and convincing evidence of imminent or immediate dangerousness even though they lack any professionally accepted definition or definitive actuarial tools to make such a temporal prediction.<sup>216</sup>

The Supreme Court's criteria requires courts to assume psychiatrists can accurately predict future dangerousness, but clinical studies have repeatedly demonstrated they have a limited ability to do so.<sup>217</sup> Empirical studies conducted at least since the 1970s have found that psychiatrists are

---

213. See *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975) ("A finding of 'mental illness' alone cannot justify a State's locking a person up against his will . . . . [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.").

214. See *id.* ("The court declined to adopt the criminal law standard of 'beyond a reasonable doubt' primarily because it questioned whether the State could prove by that exacting standard that a particular person would or would not be dangerous in the future.").

215. See Joseph J. Cocozza & Henry J. Steadman, *Prediction in Psychiatry: An Example of Misplaced Confidence in Experts*, 25 SOC. PROBS. 265, 273 (1978) (concluding that based on a study involving 257 cases "that the psychiatric predictions of dangerousness were not at all accurate . . . ."); Joseph J. Cocozza & Henry J. Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L. REV. 1084, 1085 (1976) (finding that predictions are "impossible" and "inappropriate" because dangerousness is not clearly defined, the mentally ill are not often arrested, and it is unrealistic to expect predictions of "infrequent events"); Henry J. Steadman, *The Right Not To Be a False Positive: Problems in the Application of the Dangerousness Standard*, 52 PSYCHIATRIC Q. 84, 85 (1980) (speaking of the predictive nature of the "dangerousness" characterization).

216. See Robert I. Simon, *The Myth of "Imminent" Violence in Psychiatry and the Law*, 75 U. CIN. L. REV. 631, 636 (2006) ("No actuarial instrument can predict 'imminent' violence. No agreed upon definition of 'imminent' exists.").

217. See, e.g., Jeffrey S. Janofsky et al., *Psychiatrists' Accuracy in Predicting Violent Behavior on an Inpatient Unit*, 39 HOSP. COMMUNITY PSYCHIATRY 1090, 1090 (1988) (discussing the risks of judicial and legislative belief in psychiatrists predictive power about future dangerousness); Philip Saragoza & Melvin Guyer, *Psychiatric Diagnosis Delays Parole*, 37 J. AM. ACAD. PSYCHIATRY L. 127, 129 (2009), available at <http://www.jaapl.org/cgi/reprint/37/1/127> (discussing courts' acceptance of "psychologist's opinions at face value" because of the courts unawareness "of the clinical questions and the limits of scientific evidence concerning the accuracy of predictions of future dangerousness").

no better at predicting future dangerousness than laymen.<sup>218</sup> While predictive methods have improved, social science literature continues to demonstrate that clinical diagnoses of future harmful behavior are often erroneous.<sup>219</sup> This finding is particularly troubling given that courts evaluating psychiatric testimony in civil commitment cases will not subject the evidence to beyond a reasonable doubt scrutiny,<sup>220</sup> thereby increasing the likelihood that, besides a mistaken assessment, a patient might also be subject to the wrongful deprivation of liberty.

Sometimes biases, based on irrelevant factors like gender, influence diagnoses.<sup>221</sup> A survey of eighty-one mental health professionals indicated that the gender of the clinician alters the diagnoses of patients' dangerousness.<sup>222</sup> Female clinicians are more likely than male clinicians to find male patients to be dangerous.<sup>223</sup> Using the beyond a reasonable doubt standard to prevent this error from tainting courtroom proceedings, a finder

---

218. See 1 Michael L. Perlin & Heather Ellis Cucolo, *Preface* to MENTAL DISABILITY LAW: CIVIL AND CRIMINAL LAW: CIVIL AND CRIMINAL at iii (2d ed. Supp. 2007) ("The voluminous literature as to the ability of psychiatrists (or other mental health professionals) to testify reliably as to an individual's dangerousness in the indeterminate future had been virtually unanimous."). Another review of the literature likewise found that "mental health professionals have yet to demonstrate any special ability to predict violence." Tomas R. Litwack & Louis B. Schlesinger, *Assessing and Predicting Violence: Research, Law, and Applications*, in HANDBOOK OF FORENSIC PSYCHOLOGY 226 (Irving B. Weiner & Allen K. Hess eds., 1987). A recent study demonstrated enormous flaws with the United Kingdom's Department of Health's algorithms for predicting whether people with dangerous personality disorders are at risk of re-hospitalization after release. See Christine Evans-Pughe, *Forecasting Human Behaviour Is Risky*, GUARDIAN (U.K.), July 19, 2007, at 5 ("When applied to individuals the margins of error are so high as to render any results meaningless.").

219. Meta-studies analyzing clinical data on the prediction of future are John Monahan, *Violence Risk Assessment: Scientific Validity and Evidentiary Admissibility*, 57 WASH. & LEE L. REV. 901, 903–05 (2000) (observing that research of evaluations of different clinical approaches to diagnosing a risk of future threats shows little accuracy in any approach) and Alexander Scherr, *Daubert & Danger: The "Fit" of Expert Predictions in Civil Commitments*, 55 HASTINGS L.J. 1, 17–25 (2003) (finding that various studies have shown that different approaches to future danger assessment have not proven accurate).

220. See *supra* notes 166–76 and accompanying text (explaining why the criminal burden of proof will no longer be used for civil commitments of the mentally ill).

221. See, e.g., Eric B. Elbogen et al., *Gender and Perceptions of Dangerousness in Civil Psychiatric Patients*, 6 LEGAL & CRIMINOLOGY PSYCHOL. 215, 224 (2001) (describing a study that found gender bias in mental illness diagnoses).

222. See *id.* (showing the subjectivity of "dangerousness to self").

223. See *id.* (discussing an empirical study that found "clinician's gender had a significant interaction with the patient's gender with respect to how dangerousness was judged: [F]emale clinicians perceived a greater gender gap in violence than did male clinicians.").

of fact may determine that a clinician made a mistake about a defendant's dangerousness based on a gender stereotype. "This is somewhat troubling," the study's authors concluded, "because individuals might be involuntarily hospitalized not because of any of their own characteristics, but instead in part based on the characteristics of their evaluators."<sup>224</sup> Close judicial analysis of the evidence is essential to avoid depriving persons of their liberty who do not objectively pose a threat of harm to themselves or others.

Adding to the complication of assessing the evidence, many state statutes' criteria for evaluating dangerousness are ambiguous. For instance, Louisiana defines "dangerous to others" to mean, "the condition of a person whose behavior or significant threats support a reasonable expectation that there is a substantial risk that he will inflict physical harm upon another person in the near future."<sup>225</sup> "Dangerous to self" is similarly diagnostically subjective. The statute defines it to mean, "the condition of a person whose behavior, significant threats or inaction supports a reasonable expectation that there is a substantial risk that he will inflict physical or severe emotional harm upon his own person."<sup>226</sup> Without empirical requirements

224. *Id.*

225. LA. REV. STAT. ANN. § 28:2(3) (2009).

226. *Id.* § 28:2(4). A modified version of the ambiguity problem in mental health statutes are laws that have some empirically testable criteria but nevertheless allow for subjective judgments. An example of this type of statute is the North Carolina's Mental Health Act. Its first criterion for identifying an individual who is "dangerous to himself" allows for broad discretion, while the second and third criteria are more specific. "Dangerous to himself" means that within the relevant past:

1. The individual has acted in such a way as to show:

I. That he would be unable, without care, supervision, and the continued assistance of others not otherwise available, to exercise self-control, judgment, and discretion in the conduct of his daily responsibilities and social relations, or to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety; and

II. That there is a reasonable probability of his suffering serious physical debilitation within the near future unless adequate treatment is given pursuant to this Chapter. A showing of behavior that is grossly irrational, of actions that the individual is unable to control, of behavior that is grossly inappropriate to the situation, or of other evidence of severely impaired insight and judgment shall create a prima facie inference that the individual is unable to care for himself; or

2. The individual has attempted suicide or threatened suicide and that there is a reasonable probability of suicide unless adequate treatment is given pursuant to this Chapter; or

3. The individual has mutilated himself or attempted to mutilate himself and that there is a reasonable probability of serious self-mutilation unless adequate treatment is given pursuant to this Chapter.

N.C. GEN. STAT. § 122C-3(11)(a) (2009).

that might be verifiable by ordinary medical means, challenges to diagnoses are best adjudicated by a neutral finder of fact to be beyond a reasonable doubt.

Despite their low reliability in some states, as in Maryland, the initial assessment of dangerousness can be made by a physician, psychologist, social worker or nurse practitioner without getting a judge's endorsement.<sup>227</sup> A retrospective study of 300 patients found that only 47% of the conduct described in an emergency petition might have been classified as criminal.<sup>228</sup> These findings indicate the plasticity of the term "dangerousness" and the need for legal criteria rather than solely clinical diagnoses.<sup>229</sup> This finding is consistent with older studies which discovered the extremely high rate of mistakes in dangerousness assessments. These studies were available at the time the Supreme Court established the clear and convincing standard in *Addington*: That finding yielded symmetrically false positive results for both groups.<sup>230</sup> A 183-participant study conducted at a New York psychiatric hospital found that psychiatrists only predicted future dangerous behavior in 71% of the cases.<sup>231</sup> It may be argued that a

---

227. See Jeffrey S. Janofsky & Anthony C. Taburell, *Diversion to the Mental Health System: Emergency Psychiatric Evaluations*, 34 J. AM. ACAD. PSYCHIATRY L. 283, 284 (2006) ("A licensed physician, psychologist, social worker, or nurse practitioner who has examined the patient may endorse and have an EP acted on by police without a judge's endorsement.").

228. *Id.* at 285–87. Thirty-four percent of the people who were brought to the hospital on an emergency petition were involuntarily committed. *Id.* at 288. Counterindications came from a study by Steven P. Segal, an advocate of civil commitment, which concluded that diagnosticians can consistently identify dangerousness in severely mentally ill patients. Steven P. Segal et al., *Civil Commitment in the Psychiatric Emergency Room*, 45 ARCHIVES GEN. PSYCH. 753, 758 (1988).

229. See Segal, *supra* note 228, at 758 (describing the findings that indicate the plasticity of the term "dangerousness").

230. See Henry J. Steadman & Joseph Cocozza, *Psychiatry, Dangerousness and the Repetitively Violent Offender*, 69 J. CRIM. L. & CRIMINOLOGY 226, 228 (1978) (describing a study that found that 51% of individuals classified as dangerous and 39% of individuals classified as nondangerous were assaultive during hospitalization, yielding symmetrical false positive results for both groups).

231. See Robert Burton, *Who Will Go Nuts?: Predicting Mental Illness Is Usually No Better Than Gambling, But We Keep Trying*, SALON, Dec. 6, 1999, [http://www.salon.com/health/col/bob/1999/12/06/dr\\_bob](http://www.salon.com/health/col/bob/1999/12/06/dr_bob) (last visited Feb. 16, 2011) ("A study at a New York psychiatric hospital, published last month, analyzed the ability of the treating psychiatrists to predict who, among 183 male patients, were likely to show assaultive behavior during the following three-month period. Their accuracy rate was 71[%]; 29[%] of future violent patients were not identified.") (on file with the Washington and Lee Law Review). A psychologist at the University of Virginia School of Law, John Monahan, evaluated major scientific studies about psychiatrists' ability to predict violence

71% accuracy rate is fairly high given the potential of dangerous mentally ill persons causing danger in a community. When considered from a perspective of individual rights, however, a 29% failure rate, especially when it can lead to long-term, inpatient psychiatric treatment, is too high to lightly demand anything less than certainty for involuntary commitments. Without a beyond a reasonable doubt finding about an individual's actual status, commitment decisions often turn on convincing but uncertain assessments.

A greater difficulty occurs in the evaluation of patients involuntarily brought to emergency rooms for commitment.<sup>232</sup> In 1973, a Stanford University professor, David L. Rosenhan, conducted an experiment to demonstrate the potential for error in the emergency setting.<sup>233</sup> Rosenhan instructed eight ordinary people to pose as patients in order to gain voluntary admission to twelve different hospitals.<sup>234</sup> Among the eight were a psychiatrist and pediatrician.<sup>235</sup> The "pseudopatients" claimed their only symptom was hearing undefined voices saying "empty," "hollow," and "thud"—nothing more.<sup>236</sup> Except for falsifying their names, vocations, and

---

and found that "10[%] of those evaluated as not violent and about 30[%] of those evaluated as prone to violence will commit an act of violence in a five-year period." Daniel Goleman, *Tough Call for Psychiatrists: Deciding Who Is Dangerous*, N.Y. TIMES, July 13, 1986, at A1.

232. An indication of the subjectivity of psychiatric diagnosis is the frequency of clinicians' disagreements. One study used the records of inpatient, outpatient, rehabilitation, case management, and emergency services to conclude that there was only a 53% agreement among community psychiatrists and final research diagnoses. Monica R. Basco et al., *Psychiatric Diagnoses in Community Mental Health: Accuracy and Cost*, in 11 AHSR FHSR ANNUAL MEETING ABSTRACT BOOK 8 (1994) ("Reliability of diagnoses made by community psychiatrists when compared to the final research diagnosis rendered by the study psychiatrist/psychologist was Kappa = .45 (53% agreement)."). Other studies have found that foster child institutionalizations are often impacted by irrelevant factors like the children's relationship with their foster or adoptive parents. Jessica A. Snowden et al., *Evaluating Psychiatric Hospital Admission Decisions for Children in Foster Care: An Optimal Classification Tree Analysis*, 36 J. CLINICAL CHILD & ADOLESCENT PSYCHOL. 8, 16 (2007) (finding that some factors of psychiatric hospitalization "such as level of problems in birth or adoptive family, screening location, and the presence of emotional problems or symptoms of posttraumatic stress disorder, are not part of the current thinking about the conditions that justify a hospitalization").

233. See David L. Rosenhan, *On Being Sane in Insane Places*, 179 SCI. 250, 251 (1973) (laying out the basis and reason for the experiment: To see if there were errors in diagnoses).

234. See *id.* ("Eight sane people gained secret admission to [twelve] different hospitals.").

235. See *id.* ("Among them were three psychologists, a pediatrician, a psychiatrist, a painter, and a housewife.").

236. *Id.*

employers, the pseudopatients exhibited an accurate portrait of their personal lives and histories.<sup>237</sup> The pseudopatients described:

Relationships with parents and siblings, with spouse and children, with people at work and in school . . . [f]rustrations and upsets . . . along with joys and satisfactions. . . . If anything, they strongly biased the subsequent results in favor of detecting sanity, since none of their histories or current behaviors were seriously pathological in any way."<sup>238</sup>

All eight were nevertheless admitted to psychiatric wards.<sup>239</sup> After they were admitted, the pseudopatients exhibited ordinary behavior traits, like keeping the rules of the ward, and informed the hospital staff they no longer experienced the symptom.<sup>240</sup> All of the pseudopatients, except for one, were diagnosed with schizophrenia and held an average of nineteen days.<sup>241</sup>

While the Rosenhan study was conducted more than thirty-five years ago, it continues to be a thorn in the side of leading psychiatrists.<sup>242</sup> In 2005, Robert Spitzer, who was the chief for revisions of the key psychiatric manual, DSM,<sup>243</sup> sent 431 questionnaires attempting to test a critique of Rosenhan's study by Lauren Slater.<sup>244</sup> Spitzer's written survey described the same symptoms as "Slater's description of her appearance and

237. *See id.* ("Beyond alleging the symptoms and falsifying name, vocation, and employment, no further alterations of person, history, or circumstances were made.")

238. *Id.*

239. *See id.* (stating that the eight pseudopatients were admitted to psychiatric wards).

240. *See id.* at 252 ("When asked by staff how he was feeling, he indicated that he was fine, that he no longer experienced symptoms. He responded to instructions from attendants, to calls for medication (which was not swallowed), and to dining-hall instructions.")

241. *Id.*

242. *See* Michael Brus, *Take the Shrink Challenge: Can a Psychiatrist Really Tell What's Wrong with You?*, SLATE, June 22, 2006, <http://www.slate.com/id/2144123/> (last visited Feb. 16, 2011) (calling Rosenhan's experiment "a ruse" and "an albatross for psychiatry") (on file with the Washington and Lee Law Review).

243. *See id.* (reporting that "Spitzer . . . spearheaded the revision of the DSM in 1980").

244. Robert L. Spitzer, *Rosenhan Revisited: The Scientific Credibility of Lauren Slater's Pseudopatient Diagnosis Study*, 193 J. NERVOUS & MENTAL DISEASE 734, 736 (2005). Psychologist Lauren Slater attempted "to test the hypothesis that psychiatric diagnosis depends largely or entirely on situational context rather than on the psychiatric status of patients," thus making her experiment, as she saw it, "a test of the hypothesis examined in Rosenhan's (1973) famous study, 'On Being Sane in Insane Places.'" *Id.* at 734. Slater's test consisted of her entering a certain number of emergency rooms claiming certain symptoms, and she "reported that she was diagnosed with psychotic depression almost every time she presented to the admitting psychiatrist with the lone symptom of hearing the word 'thud,' despite her denying symptoms of any other psychiatric disorder." *Id.* at 735–36.

behaviors in her study as closely as possible."<sup>245</sup> Fifty-six percent of respondents diagnosed psychosis "not otherwise specified," 6% diagnosed psychotic depression, and another 6% made some other diagnosis.<sup>246</sup> Eighteen percent said they would hospitalize the patient for further diagnosis, and 34% indicated they would prescribe an antipsychotic medication.<sup>247</sup> This supposed follow-up study is problematic for several reasons. For one, it does not convincingly disprove Rosenhan's theory that psychiatrists are unreliable in assessing sanity and insanity because the study was methodologically different, not using live pseudopatients.<sup>248</sup> A further problem is that 48% of the respondents were familiar with Rosenhan's study, which is still commonly assigned in undergraduate courses, tipping them off to the study's purpose.<sup>249</sup> Further, the number of psychiatrists who thought that so benign a symptom as hearing nothing other than "thud . . . out of the blue" without any other indication of mental illness or dangerousness, was enough for hospitalization is itself disconcerting.<sup>250</sup> An involuntary commitment of this type would need beyond a reasonable doubt review rather than review under the more deferential clear and convincing evidence standard.

Beyond a reasonable doubt judicial evaluation is needed because psychiatry is so often inconsistent in its diagnoses, requiring a neutral factfinder to assess whether legal standards for involuntary commitment have been met.<sup>251</sup> A study of all psychiatry residents in Massachusetts demonstrated that "individual psychiatrists' risk-taking behavior" and level of training affected the likelihood that they would seek involuntary commitment.<sup>252</sup> Far from meeting basic due process standards, a study of a

---

245. *Id.* at 736.

246. *Id.* at 737.

247. *Id.*

248. *See* Brus, *supra* note 242 (noting that "the survey method conveniently sidesteps many of the variables that continue to plague psychiatric diagnosis").

249. *See* Spitzer, *supra* note 244, at 737 ("[F]amiliarity with the studies was common (Rosenhan, 48%; Slater, 8%)").

250. *Id.* at 736.

251. *See* S. Pirzada Sattar et al., *To Commit or Not to Commit: The Psychiatry Resident as a Variable in Involuntary Commitment Decisions*, 30 ACAD. PSYCHIATRY 191, 191 (2006) ("However, as the assessment of dangerousness requires an interpretation of the presenting facts by the evaluating psychiatrists, in the absence of a clear risk of harm, psychiatrists can disagree about the need for involuntary commitment for a particular patient." (citations omitted)).

252. *Id.* at 193. This study was based on an eighty-eight resident sample pool (208 residents were contacted, but not all returned the questionnaire). *Id.* at 192.



large community teaching hospital found that 56% of admission files in a 298-person study did not even document mental status during triage.<sup>253</sup> The risk of false-positive admissions is further aggravated because many involuntary intakes are not done by psychiatrists but emergency room physicians whose ability to make accurate diagnoses of illnesses like depression are relatively low.<sup>254</sup>

The need for judicial oversight of involuntary commitments is acute because psychiatric diagnoses rely on professional judgments, intuitions, and algorithms to a greater degree than ordinary medical diagnoses, which have more verifiable biological components.<sup>255</sup> Mental health professionals' findings in emergency settings, where initial screenings are typically performed, are often mistaken. A 10,025-patient retrospective study from Fundacion Jimenez Diaz General Hospital in Madrid, Spain found a tremendous inconsistency of diagnoses.<sup>256</sup> Of the 1,408 emergency room cases in the study, "[p]rospective consistency ranged from 44.4% for other specific personality disorders to 81.1% for bipolar affective disorder. The prospective consistency of the three most prevalent specific diagnoses at the first evaluation was 79.2% for schizophrenia, 81.1% for bipolar affective disorder and 62.5% for dysthymia."<sup>257</sup> Thus, even in the best results, 18.9% of the prospective diagnoses of bipolar affective disorder were inconsistent. The same study found that "[r]etrospective consistency at the last evaluation ranged from 41.7% for obsessive compulsive disorder to 80.0% for recurrent depressive disorder; it was 67.0% for schizophrenia,

---

253. Judith E. Tintinalli et al., *Emergency Medical Evaluation of Psychiatric Patients*, 23 ANNALS EMERGENCY MED. 859, 860 (1994). While the subjects of this study were voluntarily admitted, the laxity of recording mental diagnoses also has implications to judicial oversight of involuntary patients. *Id.*

254. See Monica Cepoiu, *Recognition of Depression by Non-Psychiatric Physicians—A Systematic Literature Review and Meta-Analysis*, 23 J. GEN. INTERNAL MED. 25, 26, 33 (2008) (analyzing thirty-six studies about nonpsychiatrist physicians' ability to diagnose accurately depression).

255. See *infra* notes 259–65 and accompanying text (noting the complexities in diagnosing mental illness and the problems with a commonly used test for mental illness, the DSM); see also Tintinalli et al., *supra* note 253, at 861 ("[E]mergency medicine health care professionals may prefer to direct attention toward patients with more tangible injuries or illnesses. . . . There may be a tendency to automatically attribute physical symptoms to the underlying psychiatric disorder.").

256. See Enrique Baca-Garcia et al., *Diagnostic Stability of Psychiatric Disorders in Clinical Practice*, 190 BRIT. J. PSYCHIATRY 210, 210 (2007) (describing the study and remarking that its "findings are an indictment of our current psychiatric diagnostic practice").

257. *Id.* at 210, 214.

70.6% for bipolar affective disorder and 69.0% for dysthymia."<sup>258</sup> Only a beyond a reasonable doubt standard for civil commitments can adequately weed out such a high rate of inconsistency from cases of actual danger and mental illness.

Diagnoses based on DSM-IVR often yield false positives<sup>259</sup> even outside the emergency room setting, which can lead to unnecessary treatments.<sup>260</sup> Although the DSM is meant to improve evaluative consistency, clinicians will often place more credence in its criteria than the context of an individual's behavior.<sup>261</sup> One of the manual's many flaws is its use of algorithmic diagnostic and treatment criteria rather than nuanced personal evaluations that transcend the DSM's symptomatological components.<sup>262</sup> The DSM also neglects to indicate the significance of events leading up to the symptoms and explanations for behaviors outside the mental illness framework.<sup>263</sup> Jerome Wakefield, professor at the school of social work at New York University, has pointed out that the high credence given to the DSM increases the likelihood that symptomatic diagnoses will lead to false positive results because of the failure to consider individual context, such as intense response to the loss of parents or children, which provide reasons for adverse emotional responses.<sup>264</sup> That

258. *Id.* at 214.

259. A "false positive" is an incorrect diagnostic finding that a patient has a specific disorder. *See* Nutan Atre Vaidya & Michael Alan Taylor, *The DSM: Should It Have a Future?*, PSYCHIATRIC TIMES, Mar. 1, 2006, at 73 (noting that "false positives" are "incorrect diagnoses").

260. *See* Jerome C. Wakefield, *False Positives in Psychiatric Diagnosis: Implications for Human Freedom*, 31 THEORETICAL MED. & BIOETHICS 5, 9 (2010) ("Treatment of disorder is the essential defining mission of psychiatry, and certainly, this mission has a special status among the many tasks undertaken by the mental health professions. Thus, the distinction between disorder and non-disorder is conceptually central to clinical theory and practice.").

261. *See id.* (suggesting that that the DSM-IV "infers that its diagnostic criteria are sufficient to identify each option and that there is no practical need to know more psychopathology than what is in the manual").

262. *See id.* (noting that "a DSM-based treatment algorithm . . . can be applied as though it were a recipe"). The DSM-IVR is a worldwide standard for psychiatric clinical and research diagnosis, and also has become the source for training residents and medical students in psychopathology and clinical diagnosis. *See id.* (noting that "[b]oth student and resident training in descriptive psychopathology now rely on" the DSM-IV).

263. *See id.* (noting that "[t]he present classification does not incorporate brain behavior relationships into diagnostic criteria because unlike some neurologic signs . . . most behavioral signs and symptoms are not as localizing").

264. *See* Wakefield, *supra* note 260, at 14 (arguing that the incidents of false positives are aggravated because the DSM attempts "to create reliable and scientific criteria, which were important goals at the time, defined disorders in terms of symptoms and thus, as a side

is, even when the DSM's mental illness criteria for involuntary institutionalization is technically satisfied, reasonable doubt may still exist as to whether the individual patient has been correctly classified.<sup>265</sup> The ambiguity of diagnoses and the high rate of false positives<sup>266</sup> leaves too much uncertainty to use the clear and convincing standard the Court established in *Addington* and uncritically relied on this term in *Comstock*. Where fundamental liberty is at stake proof of mental illness and danger must be made beyond a reasonable doubt to avoid due process violations.

Cultural and social factors should also play an important role in diagnoses, but they are rarely considered by clinical psychiatrists who rely on the DSM.<sup>267</sup> One researcher found "inordinately high rates of involuntary confinement of African American men" to be attributable to the "cultural gulf between many clinicians and their clients."<sup>268</sup> Cultural components of personality are often missing from psychiatric diagnoses, which are particularly important in evaluating immigrant communities, leading to dubious medical decisions that misconstrue aberrant behavior for psychotic symptoms.<sup>269</sup>

---

effect, largely took context out of the diagnostic criteria").

265. See CHRISTOPHER LANE, SHYNESS: HOW NORMAL BEHAVIOR BECAME A SICKNESS 62–63 (2007) ("The notion that one could slot each person into diagnostic molds ruled out other factors, such as the dynamic nature of illness . . ."); see also ALLAN V. HORWITZ & JEROME C. WAKEFIELD, THE LOSS OF SADNESS: HOW PSYCHIATRY TRANSFORMED NORMAL SORROW INTO DEPRESSIVE DISORDER 98–99 (2007) (noting "studies [that] challenged the reliability not only of distinguishing closely related diagnostic categories . . . but also of distinguishing between larger categories . . . and between overall types of disorder . . .").

266. See Vaidya & Taylor, *supra* note 259, at 73 ("Even in expert hands, reliability is marginal for psychosis, somatization, eating disorder, dysthymia, mania, generalized anxiety disorder, attention deficit hyperactivity disorder and hypochondriasis." (citations omitted)).

267. See Byron J. Good, *Culture and DSM-IV: Diagnosis, Knowledge and Power*, 20 CULTURE MED. & PSYCHIATRY 127, 129 (1996) (noting "the failure to match the nation's (and profession's) commitment to furthering knowledge of the neurobiology of mental illnesses with an equal commitment to recognizing and understanding the social origins of psychopathology and to developing effective social interventions"). Another sign of cultural subjectivity resulting in compulsory admissions is the variegated rates of commitment in various European countries. Among European Union nations, citizens of Portugal are institutionalized at a rate of 6 per 100,000, but in Finland the commitment rate is 218 per 100,000 citizens. C.L. Mulder, Correspondence, *Variations in Involuntary Commitment in the European Union*, 187 BRIT. J. PSYCHIATRY 91, 91 (2005).

268. Good, *supra* note 267, at 129–30; see also Lonnie R. Snowden et al., *Disproportionate Use of Psychiatric Emergency Services by African Americans*, 60 PSYCHIATRIC SERVICES 1664, 1669 (2009) (describing a multi-factor approach for studying why blacks seeking psychiatric intervention use emergency services at a disproportionate rate than their representation in the U.S. population).

269. See Renato D. Alarcón, *Culture, Cultural Factors and Psychiatric Diagnosis: Review and Projections*, 8 WORLD PSYCHIATRY 131, 132 (2009), available at

Other than honest mistakes resulting during the course of patient assessments, particularly in the emergency setting where it is most likely patients will be involuntarily committed, there are less benign reasons for misdiagnoses.<sup>270</sup> For one, in opposition to Supreme Court precedents some members of the psychiatric community continue to advocate for the commitment of antisocial persons who are considered mentally ill by their communities, even when the individuals poses no immediate danger to anyone.<sup>271</sup> The Court held in *Foucha v. Louisiana* that due process only permits involuntary civil commitment of persons who are both mentally ill and dangerous.<sup>272</sup> That holding came as a response to prior judicial and attorney collusion to confine people who posed no threats of harm.<sup>273</sup> Rigorous judicial inquiry can best prevent the over-reliance on paternalistic psychiatric judgments that would otherwise trump constitutional liberties.

Several studies also indicate that civil commitments are sometimes predicated on extraneous financial interests.<sup>274</sup> In 1988, the Minnesota Blue Cross and Blue Shield reported that half of the days spent by adolescents in

---

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2755270/pdf/wpa030131.pdf> (explaining that cultural factors are often not given proper weight in psychiatric diagnoses).

270. See *supra* notes 253–58 and accompanying text (noting problems and difficulties with emergency diagnoses of psychiatric illnesses).

271. See Stuart A. Anfang & Paul S. Appelbaum, *Civil Commitment—The American Experience*, 43 *ISR. J. PSYCHIATRY & RELATED SCI.* 209, 214 (2006) (noting those who "in a nominally adversarial and legally bound process seemed reluctant to place liberty rights above obvious suffering and need for treatment").

272. See *Foucha v. Louisiana*, 504 U.S. 71, 75–76 (1992) (holding that the Due Process Clause requires the State to "prove by clear and convincing evidence the two statutory preconditions to commitment: that the person sought to be committed is mentally ill and that he requires hospitalization for his own welfare and protection of others").

273. In an article, Virginia Aldigé Hiday and Lynn Newhart Smith described a study involving 860 candidates for civil commitment who were allegedly dangerous. Virginia Aldigé Hiday & Lynn Newhart Smith, *Effects of the Dangerousness Standard in Civil Commitment*, 15 *J. PSYCHIATRY & L.* 433, 436–49 (1987). The findings demonstrated that few of them presented any imminent danger:

Threats are the most frequently mentioned type [of allegedly dangerous behavior]; and threats without any accompanying action (30.3%) occur almost three and one-half times more frequently than threats with action to carry them out (8.7%). Physical attacks are the next most frequently reported, followed by unintentional harm (21.8%). Property attack is the least reported (11.3%).

*Id.* at 439–40; see also Robert D. Miller et al., *The Effects of Witnesses, Attorneys, and Judges on Civil Commitment in North Carolina: A Prospective Study*, 28 *J. FORENSIC SCI.* 829, 829 (1983) (describing a study of 388 commitment hearings that found that judges typically accepted the recommendation of states attorneys, physicians, and witnesses).

274. See *infra* notes 276–86 and accompanying text (noting multiple studies that argue that insurance coverage can influence the diagnosis and treatment of mental illness).

inpatient psychiatric wards and chemical dependency units were "medically unwarranted."<sup>275</sup> More recent studies have likewise found that whether a patient had access to public managed care plans or private insurance coverage influenced their length of mental institutionalization. A Massachusetts study of 299 involuntary commitments in March 1998 demonstrated that mental hospitals detained patients with insurance for longer periods than those without it.<sup>276</sup> The average length of stay for Medicare patients was about twice as long as that of uninsured patients' term of hospitalization.<sup>277</sup> Another empirical study conducted in Massachusetts discovered that Medicaid beneficiaries were at significantly greater risk to be committed to forensic mental hospitals against their will than persons who were not covered by Medicaid.<sup>278</sup> Such variability in lengths of institutionalization is likely based on the availability of resources rather than dangerousness and mental illness criteria.<sup>279</sup> The significant variations in length of stay can raise reasonable doubt about the constitutionality of an individual's civil commitment.

Of further cause for concern is the influence of insurance coverage on mental diagnoses. A team from the psychology department at Southern Illinois, led by Amy M. Kielbasa, conducted a study through a questionnaire with 188 respondents all of whom were members of the American Psychological Association.<sup>280</sup> The researchers concluded that the "[r]esults of this study suggest that the method by which a client pays for psychological services has a very strong influence on the diagnostic decisions of the psychologist providing the services."<sup>281</sup> Such a finding

---

275. Holly Metz, *Branding Juveniles Against Their Will: How Wayward Adolescents are Punished for the Crime of Rebellion*, STUDENT L., Feb. 1992, at 21, 28.

276. William H. Fisher et al., *Insurance Status and Length of Stay for Involuntarily Hospitalized Patients*, 28 J. BEHAV. HEALTH SERVICES & RES. 334, 338-41 (2001).

277. *Id.* at 341-42. The mean length of stay for patients with Medicare was 13.95 days, with Medicaid 11.96, private indemnity plans 10.33, and uninsured 6.55. *Id.* at 342.

278. William H. Fisher et al., *Use of a State Inpatient Forensic System Under Managed Mental Health Care*, 53 PSYCHIATRIC SERVICES 447, 450 (2002). The study's cohort included 7,966 people. *Id.* at 449.

279. See Fisher et al., *supra* note 278, at 344 (suggesting "hospitals wish to avoid both the financial losses associated with providing care for which there will be no reimbursement and the opportunity costs that could derive from providing a bed to an uninsured patient when that bed might be filled by a patient with insurance").

280. See Amy M. Kielbasa et al., *How Does Clients' Method of Payment Influence Psychologists' Diagnostic Decisions?*, 14 ETHICS & BEHAV. 187, 187-89 (2004) (describing how the study was carried out).

281. *Id.* at 192. Surveys were sent to 750 members of the Association of whom 188 responded. *Id.* at 188. The researchers sent participants "two vignettes, one describing a

leads to the conclusion that psychiatric diagnoses are malleable and can be manipulated to increase managed care reimbursements. Such variation in results is unacceptable when it comes to the potential mistakes that could lead to wrongful civil commitment because they can undermine individuals' right to procedural justice. A 2006 study, conducted by Andrew M. Pomerantz and Dan J. Segrist, deliberately modified the Kielbasa vignettes to create subjects with symptoms of depression and anxiety below the clinical level.<sup>282</sup> They too found that persons with greater sources of reimbursement through managed care plans were more likely than out of pocket patients to be diagnosed with disorders listed in the DSM-IV.<sup>283</sup> This study again demonstrated how often the availability of resources increased the number of mental illness assessments.<sup>284</sup> A study conducted in 2007 also found that a client's method of payment "for psychological services has a very strong influence" on the misdiagnosis of social phobia disorder and attention deficit hyperactivity disorder.<sup>285</sup>

My point is not that psychiatric findings should be ignored because of their potential for error; after all, no evidence is foolproof. Rather, I am arguing that the risk of erroneous deprivation of liberty should lead state legislatures to enact beyond a reasonable doubt requirements in their civil commitment statutes. The corrosive effect of the pharmaceutical companies' funding of purportedly scientific research in multiple fields of medicine is well documented.<sup>286</sup> Many studies have also shown skewed

client with depressive symptoms and another describing a client with anxious symptoms." *Id.* at 189.

282. See Andrew M. Pomerantz & Dan J. Segrist, *The Influence of Payment Method on Psychologists' Diagnostic Decision Regarding Minimally Impaired Clients*, 16 ETHICS & BEHAV. 253, 253–55 (discussing the Kielbassa study). The article notes that "this study specifically sought to examine the impact of payment method on diagnostic decisions regarding clients whose symptoms may fall below the threshold of a DSM-IV disorder." *Id.* at 255.

283. *Id.* at 255–56, 259. Of the 275 participants in the study, 86% had Ph.D., 6% Ed.D., and 7% Psy.D. degrees. *Id.* at 255.

284. See *id.* at 259 ("Specifically, these results indicate that, relative to identical clients who pay out of pocket, clients who pay via managed care are far more likely to be diagnosed with a DSM-IV disorder.").

285. Jennifer Lowe et al., *The Influence of Payment Method on Psychologists' Diagnostic Decisions: Expanding the Range of Presenting Problems*, 17 ETHICS & BEHAV. 83, 89 (2007).

286. See, e.g., Marcia Angell, *Is Academic Medicine for Sale?*, 342 NEW ENG. J. MED. 1516, 1518 (2000) ("Academic institutions and their clinical faculty members must take care not to be open to the charge that they are for sale."); Thomas Bodenheimer, *Uneasy Alliance: Clinical Investigators and the Pharmaceutical Industry*, 342 NEW ENG. J. MED. 1539, 1543 (2000) (noting that "the commercial sector . . . reduces rather than enhances the

empirical results that are linked to pharmaceutical funding of psychiatric research.<sup>287</sup> Yet it is only with the latter that forced treatment and

---

independence of investigators"); Elizabeth A. Boyd et al., *Financial Conflict-of-Interest Policies in Clinical Research: Issues for Clinical Investigators*, 78 ACAD. MED. 769, 774 (2003) ("Thus, a fundamental challenge facing administrators and policymakers is to demonstrate to all investigators, both clinical and nonclinical, that the potential for bias, pressure, and conflict is relevant to all investigators with industry relationships."); Eric G. Campbell et al., *Financial Relationships Between Institutional Review Board Members and Industry*, 355 NEW ENG. J. MED. 2321, 2326 (2006) ("More than half the IRB [institutional review board] members reported that their IRB did not have a formal process for disclosure of relationships with industry or that they did not know of one . . ."); Benjamin Djulbegovic et al., *The Uncertainty Principle and Industry-Sponsored Research*, 356 LANCET 635, 635 (2000) (noting general "concern that clinical trials sponsored by the pharmaceutical industry result in biased findings"); Curt D. Furberg et al., *Balancing Commercial and Public Interests*, 5 CURRENT CONTROLLED TRIALS CARDIOVASCULAR MED. 6, 16 (2004), available at <http://trialsjournal.com/content/pdf/1468-6708-5-6.pdf> ("Although there are strong arguments for disclosing financial interests in research to potential research participants, officials currently charged with performing this task, as well as those involved in its oversight, are struggling to do so appropriately and effectively."); Laurence J. Hirsch, *Conflicts of Interest, Authorship, and Disclosures in Industry-Related Scientific Publications: The Tort Bar and Editorial Oversight of Medical Journals*, 84 MAYO CLINIC PROC. 811, 811 (2009) (criticizing inadequate disclosing of pharmaceutical industry ties to medical research and scholarship); Joseph S. Ross et al., *Pharmaceutical Company Payments to Physicians: Early Experiences with Disclosure Laws in Vermont and Minnesota*, 297 JAMA 1216, 1220 (2007) ("We found that the laws enacted by Vermont and Minnesota requiring disclosure of payments from pharmaceutical companies to physicians and other health care professionals fail to provide the public with easy access to information about these payments."); Ashley Wazana, *Physicians and the Pharmaceutical Industry: Is a Gift Ever Just a Gift*, 283 JAMA 373, 379 (2000) ("This article questions . . . the lack of guidelines regarding resident-pharmaceutical representative interaction . . . and the allowance of industry-sponsored conference travel for residents despite the fact that these have been disallowed for physicians."); Kevin P. Weinfurt et al., *Disclosing Conflicts of Interest in Clinical Research: Views of Institutional Review Boards, Conflict of Interest Committees, and Investigators*, 34 J. L. MED. ETHICS 581, 590 (2006) ("Although there are strong arguments for disclosing financial interests in research to potential research participants, officials currently charged with performing this task, as well as those involved in its oversight, are struggling to do so appropriately and effectively."); Kevin P. Weinfurt et al., *Policies of Academic Medical Centers for Disclosing Financial Conflicts of Interest to Potential Research Participants*, 81 ACAD. MED. 113, 117 (2006) ("The authors of the report note that, although progress is being made in many AMCs [academic medical centers] in the management of financial conflicts of interest, there are still areas requiring attention.").

287. One of the comprehensive studies of pharmaceutical funding on psychiatric research details thirteen factors that financially skew scientific factfinding:

- 1) [U]sing a dose of the comparable drug that is outside of the standard clinical range,
- 2) altering the usual dosing schedule of the competing drug,
- 3) using misleading research measurement scales,
- 4) picking endpoints post hoc,
- 5) masking unfavorable side effects,
- 6) repeatedly publishing the same or similar findings for impact,
- 7) selectively highlighting findings favorable to the sponsor,
- 8) editorializing in the abstract,
- 9) publishing the obvious,
- 10) statistical obfuscation,
- 11) selecting subjects and a time frame designed to achieve a

medicalization in involuntary settings directly implicate serious due process concerns.

### VII. *Setting the Burden of Proof*

The Supreme Court's recent reliance on the clear and convincing standard for civil commitment hearings makes it highly improbable that the reform I propose will come through the judiciary.<sup>288</sup> State-by-state revisions of civil commitment statutes, however, can set a more rigorous standard of proof than the floor set by the Court. Currently, most states' statutes only provide for clear and convincing assessment of the psychiatric evidence presented against respondents to civil commitment hearings.<sup>289</sup>

The potential for erroneous commitment of unthreatening persons without major psychiatric infirmities raises some of the same due process concerns as wrongful criminal incarcerations. Receiving a fair trial was just as constitutionally relevant to Graydon Comstock when he was originally criminally convicted for the sexual exploitation of minors as it was for his postconviction involuntary civil commitment hearing.<sup>290</sup> Fairness is a prerequisite of the Due Process Clause of the Fourteenth Amendment despite the heinous nature of the crime involved in the *Comstock* case; adequately rigorous judicial scrutiny is meant to prevent the detention of innocent people and those who are not dangerous or mentally ill.<sup>291</sup> Both criminal imprisonments and civil commitments for persons adjudicated to

---

favorable outcome, 12) withholding unfavorable results, and 13) masked sponsorship.

Daniel J. Safer, *Design and Reporting Modifications in Industry-Sponsored Comparative Psychopharmacology Trials*, 190 J. NERVOUS & MENTAL DISEASE 583, 583 (2002).

288. See *United States v. Comstock*, 130 S. Ct. 1949, 1954 (2010) (upholding the constitutionality of a federal law which, so long as "the Government proves its claims by 'clear and convincing evidence,'" allowed the commitment of a prisoner under certain circumstances).

289. See *supra* Part IV (discussing the burden for civil commitments in several states and the District of Columbia).

290. See *United States v. Comstock*, 507 F. Supp. 2d 522, 526 (E.D.N.C. 2007) (describing the nature of Comstock's criminal conviction); see also 18 U.S.C. § 2252(a)(2) (2006) (punishing the sexual exploitation of minors).

291. See *Addington v. Texas*, 441 U.S. 418, 425 (1979) ("This Court repeatedly has recognized that civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection."); see also *id.* at 427 ("Increasing the burden of proof 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.").



be sexual predators involve significant deprivations of liberty and stigma.<sup>292</sup> In both areas of adjudication, fair process is essential to prevent wrongful confinement. I have argued throughout this Article that, as with criminal prosecutions, petitions for involuntary commitments raise due process concerns that are best guarded against by relying on the beyond a reasonable doubt burden of proof. Both forms of proceedings have the possibility of inadvertent errors;<sup>293</sup> therefore, forced institutionalization like incarceration requires a neutral factfinder who is unlikely to intern individuals unnecessarily.

The beyond a reasonable doubt and clear and convincing standards both differ from the most lenient standard, preponderance of the evidence.<sup>294</sup> The Supreme Court in *Addington* set the intermediate burden of proof, "clear and convincing evidence," for involuntary hospitalization cases.<sup>295</sup> Chief Justice Burger, writing for the majority, adopted the middle burden of proof because the "uncertainties of psychiatric diagnosis" might "impose a burden the state cannot meet and thereby erect an unreasonable barrier to needed medical treatment."<sup>296</sup> That reasoning countenances decreased prosecutorial burden solely because of the difficulty to prove such cases;<sup>297</sup> this is an odd conclusion given that the patient's fundamental right to liberty is at stake. Just as with criminal law, where a beyond a reasonable doubt burden of proof makes convictions more difficult in order to protect the innocent against wrongful incarcerations, the increased uncertainty about the existence of mental illness and dangerousness should dictate the highest degree of scrutiny.

---

292. *See id.* at 425–26 ("Moreover, it is indisputable that involuntary commitment to a mental hospital after a finding of probably dangerousness to self or others can engender adverse social consequences to the individual.").

293. *See id.* at 430 ("The subtleties and nuances of psychiatric diagnoses render certainties virtually beyond reach in most situations.").

294. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 271 (1986) (Rehnquist, J., dissenting) ("[B]eyond a reasonable doubt[]' . . . is presumably easier to distinguish from the normal 'preponderance of the evidence' standard than is the intermediate standard of 'clear and convincing evidence . . . .'").

295. *See Addington*, 441 U.S. at 433 (ruling that "the 'clear and convincing' standard . . . is required to meet due process guarantees").

296. *Id.* at 432.

297. *See supra* note 295 and accompanying text (noting the Court's reasoning in setting a burden of proof); *see also Addington v. Texas*, 441 U.S. 418, 430 (1979) ("That practical considerations may limit a constitutionally based burden of proof is demonstrated by the reasonable doubt standard, which is a compromise between what is possible to prove and what protects the rights of the individual.").

The difference between these two standards is significant enough that in other cases erroneous judicial instructions to a jury about which of them to use has been found to be reversible error.<sup>298</sup> For instance, a court might make a mistake if it instructs a jury to adopt the clear and convincing rather than the beyond a reasonable doubt standard in criminal cases involving the insanity defense.<sup>299</sup> Many states do not define these terms with precision.<sup>300</sup> One state supreme court called the ambiguity of the term "clear and convincing" to be a "'plague' of imprecision," signaling the extent of problems that can result from a lack of statutory guidelines.<sup>301</sup> Put simply, "proof beyond a reasonable doubt" means that the plaintiff can prove facts in the case to a near certainty, while "clear and convincing" means that the evidence demonstrates with a high degree of probability that the material portion of the case in chief is true.<sup>302</sup>

---

298. *See, e.g.*, *State v. King*, 763 P.2d 239, 246 (Ariz. 1988) (ruling "that the error was fundamental" when a jury instruction did not instruct "the jury that the clear and convincing standard is an intermediate standard, between proof beyond a reasonable doubt and proof by a preponderance of the evidence").

299. *See, e.g., id.* at 242 (looking to "legislative history" which suggested "that the 'clear and convincing' standard was an intermediate standard, and found the 'beyond a reasonable doubt' standard 'too strict' a standard to place upon a defendant claiming insanity").

300. The Kentucky Supreme Court exemplifies judicial ambivalence in providing jurors with detailed guidelines about the meaning of these standards:

We conclude that where the "burden of persuasion" requires proof by clear and convincing evidence, the concept relates more than anything else to an attitude or approach to weighing the evidence, rather than to a legal formula that can be precisely defined in words. Like "proof beyond a reasonable doubt," "proof by clear and convincing evidence" is incapable of a definition any more detailed or precise than the words involved. It suffices to say that this approach requires the party with the burden of proof to produce evidence substantially more persuasive than a preponderance of evidence, but not beyond a reasonable doubt.

*Fitch v. Burns*, 782 S.W.2d 618, 622 (Ky. 1989). A Tennessee court of appeals left the same amount of ambiguity providing only the most skeletal definition of the issue. *In re S.L.A.*, 223 S.W.3d 295, 299 (Tenn. Ct. App. 2006) ("The clear and convincing evidence standard defies precise definition. It is more exacting than the preponderance of the evidence standard, yet it does not require such certainty as the beyond a reasonable doubt standard." (citations omitted)).

301. *In re B.D.-Y.*, 187 P.3d 594, 600 (Kan. 2008).

302. *See Parker v. Parker*, 238 A.2d 57, 61 (R.I. 1968) (explaining the distinctions between the burdens); *see also id.* (noting that in a hypothetical "scale which measured the comparative degrees of proof, the 'preponderance' burden would be at the lowest extreme of our scale; 'beyond a reasonable doubt' would be situated at the highest point; and somewhere in between the two extremes would be 'clear and convincing evidence'").

Arizona case law offers sufficient judicial guidelines to differentiate the two and is indicative of the trend in courts around the country.<sup>303</sup> Courts in that state have found that the beyond a reasonable doubt standard provides factfinders greater certainty than the clear and convincing standard.<sup>304</sup> While clear and convincing evidence requires the party seeking commitment to persuade the jury that the threat of danger and proof of mental illness are highly probable, the beyond a reasonable doubt standard is more exacting.<sup>305</sup> Beyond a reasonable doubt approaches "certainty" while the clear and convincing standard only requires something closer to "firm belief or conviction."<sup>306</sup> A number of other states have also adopted the highly probable explanation for clear and convincing evidence.<sup>307</sup>

The Supreme Court of Montana has found that for the clear and convincing burden to be met "a particular issue must be clearly established by a preponderance of the evidence or by a clear preponderance of proof. This requirement does not call for unanswerable or conclusive evidence."<sup>308</sup> This intermediate standard allows even those psychiatric diagnoses that are not conclusive and may even be partially refutable to suffice for meeting the *Addington* Court's due process requirements.

The beyond a reasonable doubt standard provides the best means available for evaluating whether the petitioner seeking to institutionalize another has met the two criteria of *Addington*. Factors tending to show the existence of mental illness and danger to self or others are stigmatizing.<sup>309</sup>

---

303. See *In re Neville*, 708 P.2d 1297, 1302 (1985) ("Clear and convincing evidence is that which may persuade that the truth of the contention is 'highly probable.'" (citations and internal quotation marks omitted)).

304. See *State v. Renforth*, 746 P.2d 1315, 1316 (Ariz. Ct. App. 1987) ("The clear and convincing standard is intermediary between the rigorous criminal standard of proof beyond a reasonable doubt and the modest civil quantum of preponderance.").

305. Cf. *id.* at 1318 (Ariz. Ct. App. 1987) (ruling that the "clear and convincing evidence . . . standard is . . . less exacting than the standard of proof beyond a reasonable doubt").

306. *State v. King*, 763 P.2d 239, 243 (Ariz. 1988).

307. See, e.g., *King*, 763 P.2d at 244 (using the highly probable definition for the clear and convincing standard); *Lopinto v. Haines*, 441 A.2d 151, 155–56 (Conn. 1981) (same); *State v. Kimball*, 181 P.3d 468, 472 (Idaho 2008) (same); *Bud Wolf Chevrolet, Inc. v. Robertson*, 519 N.E.2d 135, 138 (Ind. 1988) (same); *In re B.D.-Y.*, 187 P.3d 594, 600 (Kan. 2008) (same); *State v. Kennedy*, 585 N.W.2d 385, 389 (Minn. 1998) (same); *Garrison v. CC Builders, Inc.*, 179 P.3d 867, 877 (Wyo. 2008) (same).

308. *Wareing v. Schreckendgust*, 930 P.2d 37, 43 (Mont. 1996) (quoting *In re J.L.*, 922 P.2d 459, 462 (Mont. 1996)).

309. See *supra* note 292 and accompanying text (noting the hardships that attach to commitment because of a mental illness).

Unless both can be proven to a near certainty, the liberty interests of the party challenging the commitment should significantly outweigh the government's interest to indefinitely hospitalize the respondent. The clear and convincing standard provides a high probability of proof, but proof beyond a reasonable doubt offers near certainty that civil commitment has not been erroneously imposed.

The rationale behind judicial reliance on the beyond a reasonable doubt standard in criminal cases applies equally to criminal and civil commitment cases. In *In re Winship*,<sup>310</sup> the Supreme Court made clear that the beyond a reasonable doubt standard is important to criminal proceedings to prevent the stigmatization and wrongful loss of liberty that is likely to result from erroneous incarcerations.<sup>311</sup> In *Apprendi v. New Jersey*,<sup>312</sup> the Court explained that this procedural device animated the presumption of innocence with a substantive test "to reduce the risk of imposing such deprivations erroneously."<sup>313</sup> The high bar set for the prosecution is meant to avoid a wrongful verdict based on evidentiary error.<sup>314</sup>

Involuntary mental hospitalization also involves stigma and grave loss of liberty.<sup>315</sup> The civil label attached to the proceedings should not obfuscate the risk to liberty and unnecessary stigma that a person subject to involuntary commitments may face. This is particularly true of people who have erroneously been labeled and are required to register as dangerous sexual predators. Some states, like California, require proof beyond a reasonable doubt in any civil commitment case because of the tremendous risk to personal autonomy that can result from erroneous mental facility

---

310. See *In re Winship*, 397 U.S. 358, 368 (1970) (holding that due process required that guilt must be proven beyond a reasonable doubt).

311. See *id.* at 363 (establishing that the prosecution must prove each element of a crime beyond a reasonable doubt); see also *McMillan v. Pennsylvania*, 477 U.S. 79, 103 (1986) (Stevens, J., dissenting) (asserting that proof beyond a reasonable doubt is required "because of the immense importance of the individual interest in avoiding both the loss of liberty and the stigma that results from a criminal conviction").

312. See *Apprendi v. New Jersey*, 530 U.S. 466, 483–84 (2000) (finding that any fact that increases the prison term beyond the statutory maximum must be proven beyond a reasonable doubt to a jury).

313. *Id.* (holding that a term of imprisonment beyond the statutory maximum can only be imposed upon a showing of proof beyond a reasonable doubt).

314. See *In re Winship*, 397 U.S. at 363 ("The reasonable-doubt standard plays a vital role in the American scheme of criminal procedure. It is a prime instrument for reducing the risk of convictions resting on factual error.").

315. See *supra* note 292 and accompanying text (remarking that forced commitment for mental illness can have significantly adverse consequences for the patient).

commitment.<sup>316</sup> Montana also requires proof beyond a reasonable doubt of the material facts requiring mental commitment<sup>317</sup> partially because of "the stigma involved in a civil commitment remains" after a patient is released from mental facilities.<sup>318</sup>

The personal consequences of an erroneous mental status determination extend well beyond the stigmatic considerations.<sup>319</sup> Courts balance the public interest of treating dangerous, mentally ill people against the individual interests involved in objective mental status evaluations.<sup>320</sup> States like Florida have passed legislation prohibiting discrimination against mentally ill people in recognition of the social stigma experienced by those who are currently interned in mental facilities.<sup>321</sup> Of further concern is the lifetime stigma that some people who were institutionalized have experienced after having been adjudged mentally ill.<sup>322</sup> The stigma is

---

316. See *Hubbart v. Superior Court*, 969 P.2d 584, 609 (Cal. 1999) ("In general, each period of commitment is strictly limited and cannot be extended unless the state files a new petition and again proves, beyond a reasonable doubt, that the person is dangerous and mentally impaired."). California's requirement for proof beyond a reasonable doubt in civil commitment proceedings does not extend to some other criminal procedures: For instance, civil commitment hearings do not include a presumption of innocence. See *People v. Beeson*, 99 Cal. App. 4th 1393, 1409 (Cal. Ct. App. 2002) (ruling that a statute at issue and the California Constitution both did not require "that application of the beyond a reasonable doubt standard of proof triggers a right to a presumption-of-innocence-like instruction").

317. See *In re Mental Health of T.J.D.*, 41 P.3d 323, 325 (Mont. 2002) ("The standard of proof at the hearing is beyond a reasonable doubt with respect to any physical facts or evidence . . .").

318. *Id.* at 326.

319. See *Godwin v. State*, 593 So. 2d 211, 214 (Fla. 1992) (noting a scenario where "other consequences may follow an involuntary commitment" such "as some restrictions on a person's privileges and opportunities").

320. See, e.g., *id.* at 215 (Kogan, J., concurring in part, dissenting in part) (cautioning that "if for no reason other than the historical stigma of mental disability, I believe that an order of civil commitment by its very nature involves many important collateral legal consequences").

321. See, e.g., FLA. STAT. § 760.22(7) (2010) (stating that "[h]andicap" means: . . . A person has a physical or mental impairment which substantially limits one or more major life activities, or he or she has a record of having, or is regarded as having, such physical or mental impairment"); *id.* § 760.23(1) ("It is unlawful to refuse to sell or rent after making a bona fide offer, to refuse to negotiate for the sale or rental of, or otherwise to make unavailable or deny a dwelling to any person because of . . . handicap . . ."); *id.* § 760.23(2) ("It is unlawful to discriminate against any person in the terms, conditions, or privileges of sale or rental of dwelling, or in the provision of services or facilities in connection therewith, because of . . . handicap . . .").

322. See, e.g., *Commonwealth ex rel. Finken v. Roop*, 339 A.2d 764, 767 n.4 (Pa. Super. Ct. 1975) (explaining that the case was not moot even though appellant had been released from mental hospital because "the collateral consequences and stigma of being adjudged mentally ill remain to plague appellant throughout his life"); *In re D.B.W.*, 616

a social problem that is not the patient's fault and can only be corrected through greater sensitivity to the needs of the mentally ill.<sup>323</sup> But with courts noting its manifestation in the experiences of multiple patients, the need for the utmost judicial care in preventing wrongful institutionalization is evident.<sup>324</sup>

Requiring specific, credible, and unambiguous evidence is the most effective way of preventing erroneous deprivations of liberty. While emergent detentions might not always meet these criteria, there should be some civil recourse against anyone making false claims when later diagnosis identifies the patient is either not mentally ill or dangerous. This remedy for false confinement will diminish false claims resting on pretense, personal vendetta, financial self-interest, or other illegitimate purposes.<sup>325</sup>

### VIII. Conclusion

The *Addington* Court established the clear and convincing standard of proof for civil commitment proceedings even though it recognized that psychiatric evidence is often ambiguous.<sup>326</sup> During the current Supreme Court term, the majority in *United States v. Comstock* reconfirmed the sufficiency of that level of evidentiary scrutiny.<sup>327</sup> The Court failed to reflect on psychiatric literature demonstrating that inaccurate diagnoses and financial incentives can lead to unnecessary confinement in mental treatment facilities.<sup>328</sup>

---

P.2d 1149, 1150–51 (Okla. 1980) ("D.B.W. is saddled with the collateral consequences of commitment. The legal disabilities and social stigmatization as the result of having been declared in need of mental treatment, and committed to a mental institution remain."); *In re McCaskill*, 603 N.W.2d 326, 331 (Minn. 1999) (recognizing that "collateral consequences attach to appellant's commitment").

323. See, e.g., *Godwin*, 593 So. 2d at 215 (Kogan, J., concurring in part, dissenting in part) ("The law itself is beginning a process of rooting out acts of irrational prejudice based on mental disability, just as the law in the 1960s began eliminating the irrational bigotry posed by racism.").

324. See, e.g., *In re Mental Health of T.J.D.*, 41 P.3d 323, 326 (Mont. 2002) (noting that "the stigma involved in a civil commitment remains"); *In re S.J.*, 753 P.2d 319, 320 (Mont. 1988) (noting that "Montana's civil commitment laws are to be strictly followed").

325. An analytic presentation of such a cause of action will be the subject of another article.

326. See *supra* notes 295–96 and accompanying text (discussing *Addington*).

327. See *supra* notes 288, 290 and accompanying text (discussing *Comstock*).

328. See *supra* notes 251–66 and accompanying text (discussing difficulties and misdiagnoses in diagnosing mental illnesses); see also *supra* notes 276–85 (suggesting that medical coverage can influence a patient's commitment).

*Addington* found that there are two critical interests involved in civil commitment cases: One being the individual right to liberty and the other the social interest in hospitalizing mentally ill people who are dangerous to themselves or others.<sup>329</sup> Civil commitment involves huge deprivations of liberty—it removes an individual from family, society, acquaintances, work, and hobbies.<sup>330</sup> Even after the termination of a commitment period individuals often suffer from stigma.<sup>331</sup> The clear and convincing standard eases the prosecutor's burden of proof while increasing the risk of erroneous mental commitment. Requiring proof beyond a reasonable doubt in civil commitment hearings can significantly decrease the rate of false positive diagnoses.

---

329. *See Addington v. Texas*, 441 U.S. 418, 427 (1979) ("The individual should not be asked to share equally with society the risk of error when the possible injury to the individual is significantly greater than any possible harm to the state.").

330. *See id.* at 425 ("This Court repeatedly has recognized that civil commitment for any purpose constitutes a significant deprivation of liberty . . .").

331. *See Godwin v. State*, 593 So. 2d 211, 214 (Fla. 1992) (noting the possibility that "other consequences may follow an involuntary commitment . . . such as the stigma that society may attach").