G. E. Dix, Acute Psychiatric Hospitalization of the Mentally Ill in the Metropolis: An Empirical Study, 1968 Wash. U. Law Q. 485 (1968).

The Missouri statute which provides the legal framework for the processes discussed in this article is based on and, except in a few particulars, is similar to the Draft Act, supra.

* * *

A. *The Basic System*

There are two public facilities available to the mentally ill of St. Louis. One, the Acute Facility, provides twenty-four hour emergency room service as well as short term full time hospitalization and out-patient services; the average length of stay for a patient in the Acute Facility's full time psychiatric service in 1966-67 was 32 days. The other, the State Hospital, provides primarily longer term hospitalization as well as out-patient and followup service.[40]

* * *

40. The difference in function between the two facilities is evident from a comparison of discharges. In 1966-67, although 67 per cent of patients leaving from the State Hospital were discharged back into the community, 31 per cent of this total were patients who had died in the hospital. Eighty-four per cent of patients discharged from the Acute Facility were discharged back to the community, less than one per cent died in the hospital, and about fourteen per cent were transferred to other hospitals. (Many of these were sent to the State Hospital.) Those hospitalized in the Acute Facility, then, were most frequently released back to the community after short-term treatment; if they did not respond, they were transferred elsewhere for longer term care. A significant portion of those cared for in the State Hospital, on the other hand, remained in that facility until their death.

* * *

One other fact becomes immediately apparent from a brief overview of the system—the limited opportunity for judicial participation. In 1967, for example, about 30 per cent of the 1,917 admissions to the Acute Facility were nonvoluntary; yet during a comparable period, the probate court held far less than 575 hearings. In a large portion of nonvoluntary admissions, then, there was no formal procedural opportunity for judicial participation. This will be discussed in more detail later. Here, it is important insofar as it indicates that any study of the hospitalization procedure that concentrates on those patients that appear before the court will necessarily deal with only a small portion of those subjected to nonvoluntary hospitalization.

A more appropriate method of structuring an examination of the system is to consider several potential decision-making points along the route that patients take from the community to full-time hospitalization, to examine from empirical observation whether or not significant decisions are actually made at these points, and if so, to determine on what basis they are made. Three such points deserve discussion:

1. the decision made in the community to seek psychiatric attention for an individual and to present him for such attention, and
2. the decision made at the Acute Facility to admit the individual to full time hospitalization, and
3. the decision by the probate court to authorize further hospitalization of the patient.

B. *The Decision to Present an Individual to a Mental Facility*[52]

A study conducted in Baltimore concluded that approximately one-tenth of the nonhospitalized population exhibited "obvious mental illness."[53] There is no reason to believe that the incidence of mental

52. The basic approach in this section relies heavily upon Mechanic, *Some Factors in Identifying and Defining Mental Illness*, 46 MENTAL HYGIENE 66 (1962), reprinted in MENTAL ILLNESS AND SOCIAL PROCESSES (T. Scheff ed. 1967).

53. Pasamanick, Roberts, Lemkau & Kruger, *A Survey of Mental Disease in an Urban Population: Prevalance by Race and Income*, in MENTAL HEALTH OF THE POOR, *supra* 46, at 39, 48. Even more startling conclusions were reached in a study of the Manhattan population. Only 18.5 per cent were designated as "well." 58.1 per cent were considered mildly or moderately impaired by mental illness; despite significant symptoms, they were performing their everyday responsibilities satisfactorily. 23.4 per cent, however, were considered significantly impaired in their everyday lives by symptoms of mental illness. L. SROLE, T. LANGNER, S. MICHAEL, M. OPLER & T. RENNIE, MENTAL HEALTH IN THE METROPOLIS 138-39 (1962).

disorder is significantly lower in St. Louis, yet only a few of those exhibiting symptoms are presented to psychiatric facilities. Obviously, a very selective process operates in the community itself to choose those who are to be brought to the attention of persons in a position to offer and effect institutional treatment. The following comments concerning this selective process are based on a study of 45 randomly selected admissions to the Acute Facility. Heavy reliance was placed on medical records, but in numerous cases this was supplemented by interviews with the admitting resident.

1. *Community Selection in St. Louis*

Table 1 contains a basic breakdown of the admissions, categorized by the class of persons accompanying the patient when he appeared at the Acute Facility. In about one fifth of the cases the individual presented himself. In about four fifths someone other than the patient accompanied him to the Acute Facility and probably assisted in determining that he should be presented to a psychiatric facility. In one third of the total presentations, one or more members of the family (and no one else) accompanied the patient. In one fifth, the police alone presented him. In another fifth, both the police and a family member (or some other close associate) were involved.

Table 1 also suggests that the dynamics of admission varied significantly with the type of presentation involved. Self-Presentations, for example, constituted 22 per cent of total, but none of the nonvoluntary admissions. Family-Police Presentations, on the other hand, constituted only 18 per cent of total, but over 40 per cent of all nonvoluntary admissions. In fact, the most striking variation is the extensive participation by the police in the presentation of those patients who become nonvoluntary admissions: in over 60 per cent of the nonvoluntary admissions the police played a role, but they were involved in only about 25 per cent of the voluntary admissions. Since the dynamics of the process depended at least in part upon who was involved, a detailed examination of the several types of presentation listed in Table 1 is necessary.

a. Self-Presentation. The Self-Presentations were composed almost entirely of individuals who had observed in themselves what they in-

TABLE 1
PRESENTATION TO ACUTE FACILITY BY THOSE ACCOMPANYING PATIENT AND TYPE OF SUBSEQUENT ADMISSION

	All Admissions Examined		Voluntary Admissions Only		Nonvoluntary Admissions Only	
	No.	%	No.	%	No.	%
Self	10	22	10	36	0	0
Police Only	9	20	5	18	4	24
Family Only	15	33	10	36	5	29
Family and Police	8	18	1	3.5	7	41
Friend and Police	1	2	1	3.5	0	0
Family and Ambulance	2	5	1	3.5	1	6
Total	45	100	28	99.9	17	100

terpreted as symptoms of illness, most often depression, anxiety, or hallucinations.

ILLUSTRATION 1.
The patient, a 32 year old woman, worked as a stenographer in a law office. On the day of admission she had experienced difficulty in concentrating on her work and had made numerous mistakes. At noon she left to return home but instead checked into a hotel. She reported hearing the sounds of a train depot and the voices of old friends. Later in the afternoon, she presented herself to the Acute Facility.

None of the Self-Presentations became nonvoluntary patients, probably because underlying each Self-Presentation was a belief on the part of the individual that he was "ill" and a concomitant willingness to submit to whatever "treatment" was suggested.

b. Police Presentations. Situations that appeared to have precipitated the presentation of those patients accompanied by police officers to the Acute Facility are summarized in Table 2. "Police Only Presentations" were those where only police officers accompanied the patient at the time of his presentation. Only one of these presentations was stimulated by events occurring within the patient's family; the others were about equally divided between situations in which officers came upon the patient during the performance of relatively routine police duties and those in which the patient was called to police attention by a complaining member of the community.

"Police-Family Presentations," those in which both a police officer and a member of the family accompanied the patient to the facility,

TABLE 2
SITUATIONS PRECIPITATING PRESENTATION: POLICE AND POLICE-FAMILY PRESENTATIONS

	Total	Police Only Presentations	Police-Family Presentations		
			Initial Contact With Patient by Police	Initial Family Decision to Present	Initial Contact With Police by Patient
Events Within Patient's Family Unit	8				
suicide attempt	1	0	0	1	0
assaultive behavior	2	1	0	1	0
bizarre behavior	5	0	0	4	1
Events Outside Patient's Family Unit	10				
suicide attempt	1	1	0	0	0
bizarre behavior observed by police during routine police activity	5	4	1	0	0
complaint to police by member of the community based on patient's assaultive conduct	2	2	0	0	0
based on patient's bizarre conduct	2	1	1	0	0
Total	18	9	2	6	1

are broken down in Table 2 according to whether or not the police made contact with the patient before or after the family had probably made the decision to present the patient. "Initial Contact with Patient by Police" were cases in which the patient came to the attention of the police by means other than the efforts of the family; in each, however, the family was subsequently contacted, the decision to present was made, and at least one member of the family accompanied the patient and the police to the Acute Facility. "Initial Family Decision to Present" were those cases in which the police were called to assist in implementing the family's decision to present the patient; these, as would be expected, were stimulated entirely by events within the family. (In one case, the patient himself called police to report that his spouse had attempted to kill him; responding officers found no

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evidence of this, contacted the spouse and assisted in presenting the patient.) The family's decision to present is discussed in the next section; the concern here is with those cases in which the police were active in making the decision to present, i.e., "Police Only" and "Initial Contact with Patient by Police" presentations.

What appears to be the only study of the police decision to present a patient suggests that there are five situations in which a police officer is likely to take a person encountered to a psychiatric facility: (1) when the person has attempted suicide, (2) when symptoms of serious mental disorder are accompanied by distortions of normal physical appearance such as seizures or extreme dirtiness, (3) when symptoms are of a highly agitated form and are accompanied by actual violence or an indication of a danger of such violence, (4) when the person appears seriously disoriented, and (5) when the person by acting incongruously has created a nuisance in a public place.[54] The cases observed in this study generally confirm this analysis.

In five cases, police contact with the patient came during relatively routine police activity. In two of these, the patient had been the driver of an automobile that had been involved in an accident; investigating officers either observed or received reports that the patient in each case had been acting abnormally. (One patient had in fact been under the influence of drugs and the other had been responding to visual hallucinations.) In the third, the patient had been stopped by police officers pursuant to what was apparently a routine traffic stop; he was obviously psychotic and the officers found an Acute Facility outpatient appointment card in his wallet. In the remaining two cases, the patient came to police attention because of serious disorientation.

ILLUSTRATION 2.
The patient was observed by police wandering on the street wearing hospital pajamas and a surgical cap. He did not respond to attempts to elicit information from him. Several hospitals in the vicinity were contacted but reported that they were not missing any patients. The patient was then taken to the Acute Facility.

In the single case in which a Police Only Presentation was stimulated by events within the family unit, the police had been called by the patient's stepmother who reported that the patient had slapped her. Upon arrival, the police observed that the patient was disoriented and that she spoke loudly but in a rambling manner. Her clothing and hair were extremely dirty.

54. Bittner, *Police Discretion in Emergency Apprehension of Mentally Ill Persons*, 14 Soc. Prob. 278, 283-286 (1967).

Similar observations may be made with regard to those patients encountered by the police in the investigation of complaints made by members of the community. In one, the patient was obviously disoriented; in another the patient's loud screaming disturbed neighbors and investigating officers found that she had lost contact with reality in several ways. The two remaining cases were situations in which the patient had inflicted violence on others or had indicated a definite intention to do so.

ILLUSTRATION 3.
A neighbor of the patient called police and reported that the patient had chased her with a hatchet. The patient, when approached, stated, "This is the hatchet Mr. Robinson used to kill me. I died once. I do not know how I came back into this world."

When the police officers were able to contact a relative or friend of an apparently "mentally ill" person, the responsibility for the individual was readily transferred to this person. Note in Table 2 the few presentations resulting from situations in which the police came into initial contact with the patient but were then able to locate the family. If the family insisted, however, the officers did assist in presentation.

ILLUSTRATION 4.
The patient, a middle aged woman who lived alone, was observed walking nude in the street late at night. Officers contacted her brother who requested that they take him and the patient to the Acute Facility. They did so.

In these cases, however, the family and not the police made the decision to present.

The position has been argued that police are frequently too selective in determining who will be presented to mental health facilities. A recent study of Negro male admissions to a Baltimore psychiatric facility, for example, reported that a large number of the patients had exhibited symptoms of serious disorder long before presentation and, while exhibiting these symptoms, had numerous contacts with the police which did not result in presentation.[55] In part, the study suggested this may have been due to general police attitudes towards lower class Negroes:

55. Brody, Derbyshire & Schleifer, *How the Young Adult Baltimore Negro Male Becomes a Maryland Mental Hospital Statistic*, Psychiatric Research Report of the American Psychiatric Association, Psychiatric Epidemiology and Mental Health Planning (1967).

> The apparent tolerance of the urban policeman to psychiatrically disturbed behavior in lower class Negro men may . . . be coupled with a tendency to view it as the naturally expected consequence of the "lack of responsibility" of members of a simple or inferior race. It is plausible to suggest that these . . . expectations . . . contribute to the development of a social role for the lower class Negro man which includes patterns of irresponsible aggressive . . . behavior.[56]

Because this study relied only upon information already available to the Acute Facility, the dynamics of the police decision cannot be discussed in any detail. Clearly more work needs to be done in this area. But one case was observed which supported the Baltimore study's conclusion that police may fail to present even seriously ill individuals.

> ILLUSTRATION 5.
> The patient believed that he was an F.B.I. agent, and he carried at least one weapon. He had accused his wife of being a "spy" and his mother-in-law of poisoning him. Three weeks before presentation he had been arrested for carrying a concealed weapon. Although it is extremely likely that he was exhibiting these symptoms at that time, he was not presented until several days before his preliminary hearing, when his wife called police and asked that they assist in presentation.

In interesting contrast to this general reluctance to present individuals encountered, however, was one admission which suggested that psychiatric hospitalization was being used by police to keep an individual believed dangerous "off the streets" when no other method was conveniently available.

> ILLUSTRATION 6.
> The patient reportedly drank one pint of whiskey and, becoming irritated at a group of children, shook one of them. Police were called and the child was taken to a hospital where it was determined that she had suffered no significant harm. The officers then took the patient to the Acute Facility and told the resident that if the patient were not admitted he would be released, as there were no charges against him. The patient exhibited no symptoms of present mental illness. When the decision to admit was made, one officer called his superior and reported in a relieved tone, "They'll take him."

The police decision to present, then, usually followed situations in which grossly bizarre behavior by the patient was observed. In addition to this symptomatic behavior, however, there was usually some

56. *Id.* at 215-16.

indication that the patient either endangered others or was unable to function in the community. Unlike the family decision to present (which will be discussed in the next section), the police decision to present apparently represented adherence to a "dangerousness" criteria. Although this meant that police agencies did probably forego opportunities to refer many mentally ill persons to psychiatric facilities, it conformed to the legal criteria set out in the statutory framework much more closely than did the family actions.

One other aspect of police presentations requires comment. The fact of police presentation created a strong pressure for admission without regard to the proposed patient's willingness to undergo hospitalization, since the Acute Facility recognized that the police seldom presented an individual unless he was a serious disruptive influence in the community and other resources had been exhausted. Nevertheless, as Table I shows, five of the nine police presentations admitted themselves on a voluntary basis. One was presented after a suicide attempt; it is probable that he recognized his "need" for treatment. In the other four cases, however, it is unlikely that the admission was voluntary in a realistic sense. In two cases, it was clear that the patients regarded hospitalization as the only alternative to jail. In the other two, the Acute Facility would have admitted the patients on a nonvoluntary basis had they not admitted themselves. It is likely that if the patients did not believe that jail was the only alternative to admission, they were aware that they had no real choice to make and acted in response to this knowledge.

c. Family (and Police-Family) Presentations. In over half of the total number of admissions studied, the family was involved in the presentation. In 33 per cent of the total admissions, the presentation had been made by the family alone. When other categories are compared, it appears that the family was influential in the presentation of over half of the 46 patients whose admissions were examined.

Table 3 breaks down the 26 admissions in which the family participated in the presentation. In eight (slightly less than one third), presentation was apparently stimulated by the family's observation of what it interpreted as "symptoms" of an "illness" for which the patient needed "treatment." In those remaining, however, there was strong evidence that presentation was stimulated by something other than a simple conclusion on the part of the family that the patient was "sick" and "needed treatment."

In 13 cases presentation was stimulated by the patient's behavior

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TABLE 3
SITUATIONS PRECIPITATING PRESENTATION: POLICE-FAMILY AND FAMILY ONLY PRESENTATIONS (BY TYPE OF ADMISSION)

	Total	Police-Family Presentations		Family Only Presentations*	
		Nonvoluntary Admissions	Voluntary Admissions	Nonvoluntary Admissions	Voluntary Admissions
Situations Within Family Unit	(21)				
suicide attempt	1	1	0	0	0
violent conduct	1	1	0	0	0
family fear of suicide	1	0	0	0	1
family fear of violent conduct	4	2	0	2	0
family disruption caused by patient's behavior	6	2	0	2	2
family observation of "symptoms of illness"					
depression	3	0	0	0	3
bizarre behavior	5	0	1	0	4
Situations Extending Beyond Family Unit	(5)				
wandering	2	0	1	1	0
boisterous and disorderly behavior	1	1	0	0	0
other	2	1	1	0	0
Total	(26) 26	8	3	5	10

* For purposes of this table, Police-Family Presentations includes those cases designated in Table 1 as "Friend and Police" and "Family and Ambulance" Presentations.

within the family. In about half of these, there was evidence that the behavior was simply disruptive of family life and that this stimulated presentation.

ILLUSTRATION 7.
The family reported that for the last two months the patient had been sleeping poorly and his general level of activity had increased. He spent money freely and the family was consequently forced into debt. Recently he had attempted to open several new charge accounts. The family also complained of the patient's argumentativeness and "resentfulness" at home and repeated complaints of his irritability at work.

In only two of the 26 cases was there a specific act which indicated a direct and serious danger of physical harm to the patient or others; in both of these cases the police assisted in presentation and the patient refused to admit himself. In five of the 26 cases, however, the family's fear of assaultive or suicidal actions appeared to have stimulated presentation.

In about one fifth of the 26 cases, the patient's symptomatic behavior became "public" in the sense that it could be observed by people other than the patient's immediate family and it appeared that the impact of this behavior on those outside the family unit was influential in stimulating admission. In these cases, the dynamics of the decision to present often differed significantly from those in which the entire matter was an internal family affair. In some of the "public behavior" cases those outside the family who were exposed to the patient's condition put strong pressure on the family to present the patient.

ILLUSTRATION 8.
A woman who had been discharged from psychiatric hospitalization during which she had been diagnosed as paranoid schizophrenic began to exhibit symptoms again. She was "abusive," paraded around her home in the nude in front of her children and charged her husband with drugging her and inviting neighbors to have sexual relations with her. She also accused her neighbors of "wanting to get rid of her." She was not presented to the Acute Facility, however, until the landlord, in response to complaints made by the neighbors, threatened to evict the family unless she was rehospitalized.

In other cases, the decision to present was made and effectuated in part at least by those nonfamily members who came into contact with the patient.

ILLUSTRATION 9.
The patient, a nineteen year old youth, had dropped out of high school because of a "nervous condition." He had been employed in a bakery but his employer called the family to take him home because he had been "acting strangely." The patient then became withdrawn and frequently paced the floor all night. Occasionally he would strike his brothers and sisters. Two days before presentation he swung at his mother with an iron bar and attempted to strangle his sister. No outside help was sought, however. On the day of presentation, he barricaded himself in the cellar and covered himself with soot and cobwebs. No attempt was made to obtain help until he left the cellar and ran out of the house. At this point, the police were called and the patient was apprehended

and presented by the mother and police officers to the Acute Facility.

In four of the five cases where the patient's symptomatic behavior was public, the police were involved in presentation. In only two of the five did the patient admit himself.

Most of the work that has been done on the dynamics of the decision to present has concerned the family decision to seek psychiatric help for one of its members.[57] These studies tend to agree with the results arrived at here. Polack, in his extensive examination of what he characterizes as the "crisis of admission"[58] suggests that the situation precipitating admission is frequently only the most recent in a series of crises involving the patient and his family. The series, he argues, is generally made up of common situations that confront most individuals and families in the course of life, such as separation, physical illness and death. Those families in which the crisis series is interrupted by the psychiatric hospitalization of one of the members have dealt with prior crises by simply denying the reality of the facts of the crisis, failing to use potential sources of help (sometimes because of reluctance to do so but frequently because the community has failed to make such resources readily available), and by failing to express negative feelings appropriate to the crisis. Hospitalization occurs when, during one of these crises, the family, frequently after exhausting other means of resolving the situation, attempts to relieve the crisis by labeling one of the members as "mentally ill" to secure this member's removal from the family.

> [P]atients were admitted to the psychiatric hospital not primarily because they had the signs and symptoms of psychiatric illness, but usually because their behavior could no longer be tolerated by the people with whom they lived. . . . Most commonly . . . hospitalization became necessary either because the patient's behavior had changed in a direction which the members of his living group found more difficult to tolerate, or because the structure of the living group changed so that its members were less able to tolerate his behavior. This behavior may or may not have been related to the patient's psychiatric symptoms . . . . We agree with a number of other workers who have observed that the member of the family who is labeled the patient is not necessarily the individual with the greatest problem.[59]

57. *See, e.g.*, Yarrow, Schwartz, Murphy & Deasy, *The Psychological Meaning of Mental Illness in the Family*, 11 J. Soc. Issues 12 (1955). *See also* Sampson, Messinger, Towne, Ross, Livson, Bowers, Cohen & Dorit, *The Mental Hospital and Marital Family Ties*, 9 Soc. Prob. 141 (1961). *Cf.* Blackwell, *Upper Middle Class Expectations About Entering the Sick Role for Physical and Psychiatric Dysfunctions*, 8 J. Health & Soc. Behavior 83 (1967). For a general study of the process of identifying those "needing" hospitalization in England and some procedural implications, see A. Lawson, The Recognition of Mental Illness in London (1966).

58. Polak, *The Crisis of Admission*, 2 Soc. Psychiatry 150 (1967).

This is not to say, however, that hospitalization which results from family rejection or inability to tolerate the patient's behavior does not serve a function other than removal of the patient from the crisis situation. Frequently hospitalization provides an opportunity for "crisis remission," in which the family regroups itself and, sometimes with outside help, becomes able to again tolerate the patient. A recent study of married women psychiatric patients documented this function of the hospitalization process:

> [A]n important if explicit function of mental hospitalization is to preserve and reinforce the patient's ties to a personal community. . . . [T]he immediate effect of hospitalization . . . is to define the wife as mentally ill and remove her from the family. These radical procedures initiate a personal and social moratorium. During the moratorium, the wife's role obligations are suspended without being abrogated; past and present expressions of alienation may be reinterpreted, isolated, and forgotten by the patient and her intimates; and critical relationships may be negotiated, modified, and resumed under conditions of limited contact and experimental tentativeness.[60]

One half of those patients whose family was influential in the decision to present were admitted on a nonvoluntary basis. A significantly higher percentage of Police-Family presentations were nonvoluntary, probably reflecting a continuation of the patient's resistance that caused the family to summon the police to assist in presentation. But the fact that one third of the Family Only presentations were nonvoluntary suggests that even when informal family pressure was sufficient to cause an individual not to resist presentation, it was nevertheless sometimes not sufficient to cause him to admit himself. It is also clear that the patient's willingness to admit himself differed with the nature of the event precipitating presentation. Acts of violence within the family generally led the family to call for police assistance in presentation and ended with nonvoluntary admission; observations which the family interpreted simply as symptomatic of illness, however, were almost never followed by police participation in presentation and with-

59. *Id.* at 151, 153.

60. Sampson, et. al., *supra* note 57, at 154-55.

out exception ended in voluntary admissions. To the extent, then, that the family sought to use the psychiatric facility as a means of protection or of relieving itself of a disruptive influence, presentation and admission were likely to be nonvoluntary. When, on the other hand, the family invoked the psychiatric system to "help" an "ill" member, the patient almost invariably cooperated in presentation and admission.[61]

2. *Analysis*

a. The Dynamics of Community Selection. The observations described above make clear that there are two general types of participants in the community selection process. The first, the patient's primary group, is the family or those with whom the patient is in close everyday association. In some cases (about one-third, according to Table 3), the primary group's decision to seek medical help for one member follows the traditional model: behavior is observed which is interpreted as symptomatic of "mental illness," and when it progresses to a point where the individual is regarded as seriously in need of help, he is presented by the concerned family to a psychiatric facility. But in many cases the process is much more complex. The primary group is willing to tolerate extremely serious behavior until something—a "precipitating event"—makes it no longer feasible to tolerate the situation. This "precipitating event" is frequently fortuitous in the sense that it is not related to either progression of symptoms or seriousness of the patient's psychopathology.

ILLUSTRATION 10.
The patient had been depressed for a period of time and had considered attempting suicide for two weeks. He had specifically threatened to kill himself, but no attempt was made to present him to the Acute Facility until his wife happened to notice an apparatus apparently designed by the patient to hang himself.

61. For one of the only studies dealing with factors stimulating presentation of patients to acute psychiatric treatment facilities, see Smith, Pumphrey & Hall, *The "Last Straw": The Decisive Incident Resulting in the Request for Hospitalization in 100 Schizophrenic Patients*, 120 AM. J. PSYCHIATRY 228 (1963). After concluding that the family's fear of the patient and the patient's "general unmanageability" were more frequently factors stimulating presentation than the patient's actual assaultiveness, the study commented, "Nine types of events had been tolerated frequently [by the patient's family] without a request for hospitalization: suicidal threats, threats of harm to family members, destructiveness, shouting, obscene words, irrational talk, inexplicable behavior, wandering, and refusing to come out of a room. Suicidal attempts and actual harm to others were not tolerated." *Id.* at 230. For an excellent general discussion of the family and community aspects of acute psychiatric hospitalization as well as criticism of the manner in which the decision to hospitalize is made, see Knight, *Social and Medical Aspects of the Psychiatric Emergency*, in CRIME, LAW AND CORRECTIONS (R. Slovenko ed. 1966).

Sometimes the precipitating event is one that makes the patient's behavior apparent to those outside the family unit, thereby involving "secondary groups" in the decision to present. As Illustrations 8 and 9 indicate, the family is sometimes willing to tolerate even seriously dangerous behavior until the behavior extends outside the family. The "secondary group" may include the police and the neighbors; they may take direct action themselves to secure presentation or they may pressure the family into effecting presentation. This does not mean, however, that groups other than the patient's primary group demand presentation at the first sign of behavior symptomatic of "mental illness." If the behavior is not violent or otherwise seriously disruptive of everyday community life, the community is frequently willing to ignore even extremely bizarre symptomatic behavior. If the offensiveness becomes focused on one member of the community, however, his efforts are often enough to cause presentation.

ILLUSTRATION 11.
The patient had been observed by police officers for three weeks. He wandered through the downtown area with a picture of Christ around his neck and carried a wooden staff. No pressure to present existed, however, until the patient walked into a store, selected a suit of clothing, identified himself as Jesus Christ and asked that the clothing be charged to God. The store owner complained to police, who presented the patient to the Acute Facility.

Thus, the most significant characteristic of the community selection process is that it does not consistently operate on the basis of presenting to psychiatric facilities those whose illness has reached a given point on a continuum of increasingly serious psychopathology or symptomatic behavior. Rather, it frequently selects for presentation those whose symptomatic behavior becomes anti-social for reasons unrelated to the illness itself. The result is twofold. First, individuals are presented to the Acute Facility, sometimes under formal or informal coercion, who may not meet the criterion of "dangerousness." They may, as in Illustrations 7 and 8, have disrupted the lives of their families; or, as the patient in Illustration 11, they may have offended an influential member of the community; but as is discussed below, it is extremely doubtful whether these individuals can be regarded as dangerous. Second, even if an individual has exhibited behavior or symptoms that might arguably bring him within the "dangerous" criterion, this single characteristic may not have been the cause of his presentation. As Illustration 9 shows the most immediate factor in the process, and the one stimulating presentation, may have no direct relationship to the symptoms that made the patient "dangerous."

* * *

Moreover, even if the legal framework cannot control the community decision to present, it nevertheless cannot ignore it. The decision to present is a primary factor in shaping later aspects of the hospitalization process that are perhaps more susceptible to such control. The public psychiatric treatment system, unlike other systems of social control such as the criminal justice system and programs of health and safety standards, has no field staff to seek out those properly included within the control of the system. It remains essentially passive and simply accepts or rejects those presented to it by individuals or agencies which have no formal relationship to the system itself. More than the other systems, then, the public psychiatric treatment system is molded by the attitudes and practices of the community. Some studies, in fact, have concluded that the decision to present is, as a practical matter, the controlling decision in the hospitalization process. As Scheff expresses it, the fact that hospitalization is sought raises a "presumption of illness" that is uncritically accepted by medical personnel and commitment courts.[71] But even if the medical examination and the judicial hearing are not as nonfunctional as these studies suggest, the fact that an individual is regarded as in need of hospitalization by his family, neighbors, or other aspects of the community is nevertheless a significant factor in the decisions to hospitalize and commit. In view of its tremendous impact on the entire system of decision to present, this factor clearly cannot be ignored in fashioning a legal framework for the system.

C. *The Decision to Admit to Hospitalization*

Since only about one-third of those presented at the Acute Facility were admitted to full time hospitalization, it is clear that the admission procedure constituted a significantly selective decision-making process.[72] The admission decision was made by a resident physician in the Acute Facility's Emergency Room after about four minutes of observation and examination. Dissection of the decision is difficult because, like many clinical decisions, it is essentially a gestalt situation: the result of admission is the vector of numerous contributing forces and to designate one or two as determinative is often misleading. Nevertheless, it is possible to isolate at least some of the specific factors that enter into the decision.

1. *Factors Influencing the Decision to Admit*

a. Patient's Desire. Analysis of the admission decision is complicated by the fact that the formal designation of an admission as voluntary may not mean that the patient's entry was a free choice on his part. When the patient was presented by the police, for example, he may have believed or have been told that admission was the alternative to jail; this may or may not have been true.

> ILLUSTRATION 12.
> Police officers presented a 36 year old man to the Acute Facility and reported that he had become irritated at a group of children and had shaken a small girl. A medical examination of the girl revealed no significant harm, and the officers reported that they had no charges against the pre-patient. The resident, who wanted to admit the pre-patient because of the potential for violence on his part, indicated that the patient signed a voluntary admission because he believed this was the only alternative to jail.

A patient was sometimes advised by the admitting physician that if he did not sign a voluntary application he would be successfully "committed," that he should not "make things difficult." Family pressures also influenced some patients to admit themselves although they did not believe they needed hospitalization.

But it is also true that a patient hostile to hospitalization sometimes voluntarily admitted himself for reasons that were obscure and difficult to determine.

71. Scheff, *The Societal Reaction to Deviance: Ascriptive Elements in the Psychiatric Screening of Mental Patients in a Midwestern State*, 11 Soc. Prob. 401 (1964).

72. Other studies have concluded that the admission procedure is *not* selective. Scheff, *supra* note 71, at 403-04. *See also* Mechanic, *Some Factors in Identifying and Defining Mental Illness*, 46 Mental Hygiene 66, 70 (1962):

> In the two mental hospitals studied over a period of three months . . . all persons who appeared at the hospital were absorbed into the patient population regardless of their ability to function adequately outside the hospital.

It is almost certain, however, that these studies report results observed in traditional "State Hospital" systems rather than in the metropolitan acute treatment system with which this study is concerned. Other examinations of the admission stage of acute psychiatric hospitalization have established the selectivity of the process. Baxter, Chodorkoff & Underhill, *Psychiatric Emergencies: Dispositional Determinants and the Validity of the Decision to Admit*, 124 Am. J. Psychiatry 1512 (1968) (which also attempts to isolate those factors influencing the decision to admit); Ungerleider, *The Psychiatric Emergency*, 3 Archives of General Psychiatry 593 (1960).

In part, at least, the selectivity of the facility studied here was caused by space shortages. The impression was inescapable that the facility would have preferred to admit more patients and retain many for longer periods of time but was prevented from both by lack of space.

ILLUSTRATION 13.

A woman diagnosed as paranoid schizophrenic was referred to the Acute Facility from another hospital. She was actively hostile but admitted herself. The resident believed that this was because the patient's sister was already hospitalized in the Acute Facility and the patient wanted to be near her and felt the facility was beneficial for her sister and therefore would also be for her.

In most cases, however, the decision to admit was made without regard to the patient's desire, and identical criteria were applied to voluntary and involuntary admissions. An interesting exception to this was the depressed patient who was not considered a suicidal risk; he was sometimes hospitalized only if he specifically requested it. But this attitude on the part of the Acute Facility seemed to be the exception rather than the rule.

b. Danger to Self. The decision to admit was influenced by a variety of factors which can be grouped together under danger to self. The most obvious was the admitting resident's conclusion that there was a substantial danger that the proposed patient would attempt to take his own life.

ILLUSTRATION 14.

A 24 year old unemployed musician presented himself at the Acute Facility. He reported that he had been depressed for a week, had experienced crying spells, and had observed an impairment in his ability to concentrate. He admitted having had suicidal thoughts and having specifically considered the use of sleeping pills as a means of taking his life. The resident admitted him.

"Dangerousness" to self in this sense is quite clearly not a readily identifiable clinical "symptom." The medical literature contains a number of studies of suicide potential, but all emphasize the variety of factors which must be considered and the ambiguity of each.[73] An important problem, especially given the shortage of space in the facilities, is that of separating serious attempts to commit suicide which have a substantial likelihood of success from suicidal gestures which are intended only to cause someone else to respond in a desired way. The matter is complicated by the fact that the "intent" to perform only a "gesture" rather than to complete the action may not be conscious or the possibility that a gesture not intended to result in actual death may, for reasons not anticipated by the individual, be successful. In addition, it is established that an individual with suicidal intentions will frequently communicate these intentions to others before acting upon them, or at least will attempt to do so. But statements and actions which are subsequently identified as attempts to communicate suicidal intentions were often ambigious at the time they were made even if the entire situation was understood, and if the individual's overall situation was not known the actions or statements would in many cases have been of no predictive value at all.[74] The literature also emphasizes the necessity for extensive knowledge of the individual's situation for other aspects of evaluating suicide potential. Some factors which have been established as relevant to suicidal potential, such as age and sex, are readily observable in the clinical context. Others, such as the nature of the fantasies the patient experiences and his impulsiveness and flexibility in adjusting to situations, require a more extensive clinical evaluation than is possible in the emergency room situation. Some cannot be evaluated without a detailed knowledge of the individual's social history; these include, for example, the patient's cultural and religious attitudes towards death, the availability of supporting resources in the community such as family members, friends, or coworkers and any recent decline in the patient's communication with others. It is not

73. *E.g.*, C. LEONARD, UNDERSTANDING AND PREVENTING SUICIDE (1967); Litman & Farberow, *Emergency Evaluation of Self-destructive Potentiality*, in THE CRY FOR HELP 48 (N. Farberow & E. Shneidman eds. 1961); Tabachnick & Farberow, *The Assessment of Self-destructive Potentiality*, in THE CRY FOR HELP *supra* at 60; Tuckman & Youngman, *Assessment of Suicide Risk in Attempted Suicides*, in SUICIDAL BEHAVIORS (H.L.P.) Resnik ed. 1968). *Cf.* Lessee, *Apparent Remissions in Depressed Suicidal Patients*, 144 J. NERVOUS AND MENTAL DISEASES 291 (1967).

The case law is equally ambigious when invoked to determine what facts justify detention on grounds of danger of suicide. In Jillson v. Caprio, 181 F.2d 523 (D.C. Cir. 1950) the court reversed a directed verdict for defendant physician who had told police officers that he would not be responsible for what happened if the plaintiff (whom he described as "homicidal and suicidal") were not taken into immediate custody. Although the decision apparently rested on the failure to comply with a statutory requirement that the certificates of *two* physicians be obtained before an insane person who was not in a public place could be taken into custody, the case was later distinguished by the same court on the ground that under the facts "there was no eminent danger." Orvis v. Brickman, 196 F.2d 762, 763 (D.C. Cir. 1952). In *Orvis* the court held that a police officer was justified in procuring the hospitalization of a woman who had cut an artery in her wrist, was bleeding profusely, and had refused medical help. Although she informed the officer that she had cut her wrist accidentally while removing a call from her foot, the officer could see no callus. *Id.* at 766-68.

74. Yessler, Gibbs & Becker, *On the Communication of Suicidal Ideas*, 3 ARCHIVES OF GENERAL PSYCHIATRY 612, 616 (1960) concluded that 30 per cent of successful suicides (and 25 per cent of those making unsuccessful attempts) had attempted to communicate their intention to others before acting. But included as an attempt to communicate were such statements as, "Some day I will have guts enough to kill myself" and, in the context of a conversation concerning the individual's approaching court martial, "I would rather be dead than restricted." *Id.* at 615.

difficult to see why the reliability of evaluations of suicide potential remains largely untested.[75] The matter is complicated further by the fact that, even if there is a significant danger of suicide, psychiatric hospitalization may be neither legally permissible nor medically desirable. Not all who attempt suicide are "mentally ill";[76] thus a potential suicide may not meet the basic criteria for psychiatric hospitalization. Moreover, while some individuals who have attempted suicide will welcome hospitalization, others will resist it,[77] and psychiatric hospitalization may, from the therapeutic point of view, aggravate those factors that gave rise to the suicidal desire.[78] In short, there is little scientific

75. For a recent study attempting to assess the effectiveness of such evaluations, see Cohen, Motto & Sieden, *An Instrument for Evaluating Suicide Potential: A Preliminary Study*, 122 AM. J. PSYCHIATRY 886 (1966). Using the traditional methods which attempt to classify those who have made attempts on the basis of the seriousness of their intentions, the study concluded that the resulting categories were of no predictive value whatsoever. The questionnaire developed by the authors, however, enabled them to divide those who had attempted suicide into three groups which were later established to contain suicidal and nonsuicidal individuals in the following ratios: 1 to 21, 1 to 2 and 1 to 1.

Piotrowski, *Psychological Test Prediction of Suicide*, in SUICIDAL BEHAVIOR 198 (H.L.P. Resnick ed. 1968) summarizes the success of the Rorschach inkblot and other psychological tests, and concludes that "There are no valid psychological test indicators capable of predicting with any degree of accuracy whether an individual will commit suicide in the forseeable future." *Id.* at 198. Some studies have reported that at least eighty per cent of patients classified as "suicidal" (defined as "having suicidal trends") or as "nonsuicidal" were subsequently confirmed to have been correctly diagnosed. *Id.* at 199-200. But the defect in the research, Piotrowski argues, is that emphasis has been placed on discovering presently existing suicidal "intent" or "trends" rather than on predicting future specific behavior. Little attempt has been made to isolate signs which when present would reliably predict a suicide or an attempt. *Id.* at 202. Such signs would be invaluable for determining those for whom a serious risk of self-destructive behavior could be said to have been factually established, although the absence of the signs could not be said to affirmatively indicate the absence of any significant risk of self destruction. This characteristic of the research substantiates the difference in emphasis between legal and medical decisionmakers discussed in the text at note 137 *infra;* medical research has been concerned with establishing the potential need for treatment rather than with accurately predicting the probability that nontreatment will have specific adverse results.

76. C. LEONARD, UNDERSTANDING AND PREVENTING SUICIDE 273 (1967) concludes that about 35 per cent of suicides were "clearly mentally ill."

77. *See* C. LEONARD, *supra* note 76, at 23, 72, 135 (1967).

78. SUBCOMM. ON MENTAL HEALTH SERVICES, CALIFORNIA LEGISLATURE, ASSEMBLY INTERIM COMM. ON WAYS AND MEANS, THE DILEMMA OF MENTAL COMMITMENT IN CALIFORNIA 152-53 (1966) concluded that danger to self should not be a basis for nonvoluntary hospitalization:

> There is good evidence that to assume responsibility for preserving the life of a suicidal person may be the worst possible therapy. Dr. Willard A. E. Larson . . . explains:
>
> . . . orthodox suicidal precautions communicate to the patient that he is untrustworthy, indeed prone to overwhelming self destructive urges, and we give him our sanction to shed accountability for his own behavior in that we . . . are now ready to carry the full social burden of preventing his harming himself.

Cf. Harris & Myers, *Hospital Management of the Suicidal Patient*, in SUICIDAL BEHAVIOR, *supra* note 73, at 207 who argue the traditional position that treatment of a suicidal patient can be best provided in a psychiatric hospital.

support for the existence of a precise and reliable clinical ability to predict suicidal actions with any degree of accuracy, and the relationship among "mental illness," suicidal intention and the appropriateness of psychiatric hospitalization is far from settled.

But "dangerousness" to self, as the criteria was administered in the decision to admit, included more than the probability of self-inflicted violence. Danger of physical harm from sources other than the patient's own hand was also an important consideration in the decision to admit in some cases. For example, the patient's decreased ability to function normally in the community may have made him particularly susceptible to a danger that is regularly borne by many members of the community.

ILLUSTRATION 15.

The patient, a 44 year old woman, was brought to the Acute Facility by her husband who was 85 years old. He reported that she suffered from insomnia and sometimes locked herself in the bathroom. During the interview with the resident, the patient talked to the empty emergency room. Among the factors influencing the decision to admit her on an involuntary basis was the resident's observation that in her neighborhood "people were robbing and raping all the time" and that she would be particularly subject to such attacks.

c. Danger to Others. In some situations, the existence of serious mental disorder and danger to others was relatively simple and determinative; the patient in Illustration 3, for example, was admitted primarily because of her obvious loss of contact with reality and her assault upon the neighbor. But in other cases the information upon which a decision as to "dangerousness" had to be made depended on relatively vague reports from informants of untested reliability, and the inference of actual "dangerousness" was far from a necessary one given the truth of the factual assertions made by the informant.

ILLUSTRATION 16.

The patient, a 32 year old woman, was seen in the emergency on the 6th. She was given medication and the social service staff began to assist her in challenging the actions of the welfare office in terminating her AFDC payments. On the 23rd, the patient was returned to the facility by her sister. The sister reported that the

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patient had been depressed but had not taken her medication, had stated that she wished her children were dead and had given the children some unidentified medicine. The sister evidenced a great deal of concern over the safety of the children. The patient was admitted on a nonvoluntary basis; the admissions note stated that she could not be treated "safely" on an outpatient basis, principally because there was no adult member of the family to see that she took her medication and returned periodically to the clinic.

Moreover, a patient was sometimes admitted following violent conduct despite the absence of any "symptoms of mental abnormality" at the time of admission. The patient in Illustration 6, for example, was admitted despite the absence of any present symptoms of psychopathology because, according to the resident, "he should not be loose." The causal relationship between the demonstrated dangerousness and any mental illness was, of course, extremely tenuous in such cases.

In a few cases an important factor was not a fear on the part of the admitting resident that the patient would become violent, but the existence of such fear in others.

ILLUSTRATION 17.
The patient had been given a ride by a truck driver who found him hitchhiking along a highway. When the truck driver noticed that the patient had a gun, he took him to the police station. The police brought him to the Acute Facility where he refused to divulge anything other than the pronunciation of his name. He was admitted on a nonvoluntary basis.

One patient was admitted not because of a fear on the part of the admitting resident that the patient would actually engage in assaultive behavior, but rather because in the extremely unlikely event that the patient would cause harm to others, the facility would be placed in an awkward "public relations" position.

ILLUSTRATION 18.
A young man who had broken up with his girl friend became intoxicated and threatened to kill her. This threat was communicated to the police. The young man presented himself to the Acute Facility after release from jail on a peace disturbance charge. The resident indicated that he did not believe the patient had the "guts" to harm anyone but that he admitted him because the threats which the patient had made had been so widely dispersed.

"Dangerousness," then, cannot in any sense be regarded as a clinically observable symptom of a proposed patient. It is a complex evaluation of how the patient will react to what is anticipated will be his

future situation. In part, this turns upon conclusions drawn from clinically observable symptoms. But even this aspect of evaluating dangerousness is clouded with uncertainty; studies have shown that psychiatrists not only do not agree on the significance of given clinical observations, but that differences in interviewing techniques and skill result in widely different clinical observations.[79] Moreover, at least as important as clinical factors in evaluating dangerousness is the task of predicting whether the patient will encounter situations that might stimulate aggressive behavior.[80] In short, psychiatric predictions of "dangerousness" to others are at least as tenuous as predictions of serious self destructive tendencies. As one study of patients who had committed homicide concluded:

> [I]n extremely few cases was there anything that would enable the psychiatrist to predict accurately the subsequent . . . offense . . . [T]he discipline of psychiatry has not yet developed valid criteria of sufficient degree of predictive reliability to justify hard and fast distinctions *before* the act between the . . . [mentally ill] individual who is likely to commit . . . violence, such as rape or homicide, and the one who will not translate his emotional conflicts into aggressive, destructive behavior.
>
> . . . .
>
> [M]entally ill people who have committed violent and serious offenses against society are not a group apart from other mentally ill persons who have not translated their emotional conflicts into overt assaults upon others. The psychotic patients who have committed homicide run the gamut of psychiatric disorders, and . . . are not clinically distinct from psychiatric patients in general. Some "mentally ill" patients who exhibit the most acutely dis-

79. Rosenzweig, Vandenberg, Moore & Dukay, *A Study of the Reliability of the Mental Status Examination*, 117 AM. J. PSYCHIATRY 1102 (1961). This study noted that there was "poor consistency" between examinations in regard to such matters as the patient's delusions, his use of the projection defense mechanism and even his orientation; these would normally be expected to remain fairly constant, which led to the conclusion that "different interviewers may tend to bring out different manifestations of psychopathology in the patient, ..." *Id.* at 1108. In regard to the evaluation of observations the study noted that "some concepts in common clinical usage, which are usually taken for granted as being universally understood, are in fact unclear. This may be true for items . . . dealing with memory impairment, systematization of delusions, autistic vs. realistic concepts, symbolic thinking and autistic fantasy." *Id.* at 1107. *See also* Stoller & Geertsma, *The Consistency of Psychiatrist' Clinical Judgments*, 137 J NERVOUS AND MENTAL DISEASES 58 (1963).

80. Bychowski, *Dynamics and Predictability of Dangerous Psychotic Behavior*, in CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL (J. Rappeport ed. 1967) discusses the clinical aspects of such predictions. The inadequacy of a purely clinical approach is clear from the discussion.

turbed and destructive behavior have never demonstrated sufficiently directed and organized aggression to kill another, while others who are quite meek and inoffensive have on occasion killed suddenly.[81]

d. Degree of Illness. Another major consideration in the decision to admit was the degree of psychopathology which was diagnosed. In this context, psychopathology means the seriousness of the illness as determined by clinical symptoms such as hallucinations, disruption of thought process, loosening of association, etc. For example, a patient was frequently asked, "Name the last four presidents," "Start with the number one hundred and subtract seven, and then continue to subtract seven from each answer you get," or "Tell me why an apple is like a pear." Inability to recall matters regarded as common knowledge, to do simple mathematical calculations or to generalize (as by suggesting that an apple is like a pear because both are fruit) was regarded as symptomatic of impairment of mental facilities.

As Illustration 15 shows, serious psychopathology may have indicated danger to the patient or other situations which tended to encourage admission, but the degree of illness also operated as a pressure to admit, independent of its relationship to such other factors.

ILLUSTRATION 19.

A 26 year old woman had reportedly been "imagining things" since her marriage six months before presentation. She had accused her husband of spying on other men in public washrooms

81. Cruvant & Waldrop, *The Murderer in the Mental Institution*, 284 ANNALS 35, 36 (1952), reprinted *in* STUDIES IN HOMICIDE 167 (M. Wolfgang ed. 1967). *See also* M. Guttmacher, *A Review of Cases Seen by a Court Psychiatrist* in THE CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL 17, 27 (J. Rappeport ed. 1967), who concludes, after a presentation of case studies of five patients who committed homicide, ". . . I am unable to decipher in these cases any symptoms which they presented in common that might act as warning signs of impending disaster. In large measure this is due to the fact that one cannot anticipate with accuracy social situations which the . . . patient will have to meet."

There appears to be growing recognition within psychiatry that dangerousness is too often being used as a basis for nonvoluntary hospitalization. *See* Mendell, *Brief Hospitalization Techniques*, 6 CURRENT PSYCHIATRIC THERAPIES 310, 314 (1966): "[The need to protect the patient from self destruction and from harming others] is too readily invoked. There are many and much better solutions to preventing a patient from committing suicide or inflicting harm on others than simply placing him in a hospital. The potential danger to others is frequently overestimated." *Cf.* Baxter, Chodorkoff & Underhill, *Psychiatric Emergencies: Dispositional Determinants and the Validity of the Decision to Admit*, 124 AM. J. PSYCHIATRY 1512 (1968), suggesting that admitting physicians tend to overestimate dangerousness and that this tendency was more pronounced in regard to patients of lower socioeconomic class and intellectual ability and those who had greater difficulty communicating with the physician.

and believed that he had holes in the wall of their home through which he spied on her. She was presented at the facility by her husband and police officers after she called police and reported that her husband, in an attempt to kill her, had filled the apartment with gas. When police arrived they observed no gas and found the husband asleep. When the patient returned to her home, she was taken to the Acute Facility. In explaining her nonvoluntary admission, the resident emphasized her symptoms of psychosis.

e. Lack of Insight. The conclusion that a patient lacked "insight" is difficult to discuss in general terms, but such conclusions undoubtedly entered into the decision to admit. Insight, as used here, differs with the diagnosed psychopathology. If the patient was diagnosed as only neurotic or suffering from a personality disorder, insight was used by some medical personnel to refer to an understanding of the underlying psychic conflict that is viewed as causing the symptoms. But in other cases—especially when the patient was diagnosed as psychotic—insight was used to refer to an awareness that the symptoms were in fact symptoms of an illness. Thus a psycotic patient who exhibited disassociation of ideas or hallucinations but refused to acknowledge that he was "sick" was defined as lacking insight. Any substantial disagreement by the patient with the facility's diagnosis and plan of treatment was considered strong evidence of lack of insight. The ambiguity of this criterion is evident from the following illustration, which indicates that insight and judgment may for all practical purposes be defined in terms of the patient's willingness to accept moral, legal, or social norms.

ILLUSTRATION 20.

A medical report submitted to the probate court contained the following assertion offered to support the conclusion that the patient's judgment and insight were "poor": "He still sees no harm in the fact that he lived with a sixteen year old girl as husband and wife. . . [H]is reasoning at the present time is that his wife was not satisfactory at that time so why not have the girl . . ."

f. Control for Treatment Purposes. It is doubtful whether hospitalization was ever effected for "pure" treatment purposes in the sense that the "therapy" indicated required full time hospitalization.[82]

82. Hospitalization on a short term basis may be used to remove an individual from a stressful situation that is believed to have "caused" his acute episode. Mendel, *Brief Hospitalization Techniques*, 6 CURRENT PSYCHIATRIC THERAPIES 310, 315 (1966). And, in theory, full time hospitalization can be "therapeutic" in the sense that forced contact

Neither medication nor electroshock can be administered only during hospitalization. But there were frequently factors of a quasi-therapeutic nature that influenced the decision to admit. The resident's judgment as to whether the patient would faithfully take medication prescribed on an outpatient basis and return periodically to the outpatient clinic was an important determinative; the patient in Illustration 16 was admitted in part because of the anticipation that she would not take medication on an outpatient basis. Moreover, there is a significant period of time before medication actually alleviates symptoms;[83] during this period, hospitalization was sometimes used simply to control the patient while the medication took effect. Electroshock treatments are considered to have a somewhat longer lasting effect than a period of intensive drug therapy, but they must be administered over a significant period of time. The choice of a therapeutic program, especially the choice between drug therapy and electroshock treatments, was sometimes a difficult one dependent upon a variety of nonmedical factors, and the choice may have had a significant effect upon the extent to which the patient's liberty was restricted.

ILLUSTRATION 21.
The patient was presented to the Acute Facility after he had caused an auto accident while responding to hallucinations. He was diagnosed as a schizophrenic, paranoid type. The staff concluded on the basis of their experience with him after earlier hospitalizations that he would not continue to take medication after his release. The alternative course of treatment was seen as retaining him for about a week while a series of electroshock treatments were administered. But the staff also concluded that if his employer discovered that this was the reason for his absence from his job, he would be discharged. The tentative decision was

with people in an institutional setting can encourage a withdrawn patient to "reach out" and reestablish interpersonal contacts. Thus it may be theoretically beneficial for schizophrenics who frequently withdraw severely. A. CHAPMAN, TEXTBOOK OF CLINICAL PSYCHIATRY 237-38 (1967). Insofar as such institutionalization constitutes therapy, the treatment is in fact administered primarily by aids and others with extended daily contact with the patients. Programs relying heavily on such personnel (rather than trained therapists) have offered encouraging results. *See* N. COLARELLI & S. SIEGAL, WARD H. (1966). But in the acute system, the process is too rushed for this to be an important part of the program, although specific attempts are made to keep patients active and to encourage personal interaction.

83. The time required for "drug therapy" to become effective varies. For example, when phenothiazine is used to treat a schizophrenic, improvement may occur within a few days but "it usually requires from ten days to a few weeks for decisive improvement to be evident." A. CHAPMAN, TEXTBOOK OF CLINICAL PSYCHIATRY 239 (1967). The variations in time are about the same when the drug is an antidepressant. *Id.* at 405-08.

to retain him in the facility but to give him a daily gate pass to go to his job; medication would be administered during this time and its effectiveness would be later evaluated.

In a few cases, hospitalization was used for therapeutic purposes not directly related to the psychiatric illness of the patient.

ILLUSTRATION 22.
An 18 year old youth was admitted after being in an auto accident while under the influence of a drug. He denied taking amphetamines in addition to the drug which he had taken prior to the accident, but the staff psychiatrist indicated that he would be retained, involuntarily if necessary, for a week, because it was believed that he was in fact taking amphetamines and the psychiatrist expected withdrawal symptoms to develop.

g. Observation for Diagnostic Purposes. The limited period of time available during the emergency room procedure was sometimes considered to provide inadequate opportunity for diagnosis, and an accurate diagnosis was seen as important for purposes of prescribing a treatment program. Thus the need to observe the patient in a less pressured situation and over a longer period of time influenced the decision to admit.

ILLUSTRATION 23.
The patient, a 32 year old woman, was presented by her husband because he had returned after a week away to find that she had wandered to the home of an occasional acquaintance six miles away. The husband also reported that the patient had not been eating or sleeping properly and had gone to taverns alone the past three weekends. The patient reportedly told her husband that she had relations with another man and informed the resident that she was under the spell of a "wise old man." The resident indicated that a major factor in his decision to admit her as an involuntary patient was the fact that this was her first psychotic episode and that he desired an opportunity to diagnose her psychopathology.

h. Community Disruption. The decision to admit was sometimes strongly influenced by the fact that the patient's symptomatic behavior offended or irritated a portion of the community.

ILLUSTRATION 24.
The patient, a 61 year old woman, lived alone. She had a history of persecutory delusions extending back over fifteen years. On a number of previous occasions, she had screamed at the neighbors; they finally responded by calling the police. On the

occasion preceding her presentation, the neighbors specifically demanded that the police secure the patient's hospitalization. When examined at the Acute Facility, the patient indicated that she believed spirits came to her home and attempted to have "spiritual sex" with her. The resident, who admitted her on a nonvoluntary basis, indicated that a major factor in his decision was that he was not certain "how much the neighbors could take."

Patients were sometimes admitted because they disrupted the emergency room of the Acute Facility by repeated appearances there. As a rule of thumb, the Acute Facility admitted patients who appeared at the emergency room three times within a period of two weeks. Sometimes, however, the sequence of events was more complex.

ILLUSTRATION 25.
The patient, a 33 year old man, had a history of amphetamine abuse and for two years had exhibited paranoid ideas. He had reportedly made certain threats, but his family did not believe he was capable of carrying them out. He had been seen several times in the emergency room and an administrative official of the Acute Facility suggested that the next time he was seen in the emergency room he be admitted. Subsequently, the patient's car was stopped by police and he was discovered to be driving without a license. The officers found an out-patient clinic card in the patient's wallet, and they then called the Acute Facility. They were instructed to bring him to the emergency room; upon arrival, he represented himself as an Internal Revenue Agent and showed significant thought disorder. He was admitted.

i. Family Disruption or Rejection. When there was available a family which was considered able and willing to care for the patient despite his symptomatic behavior, he would frequently be released despite the existence of symptoms that would otherwise result in hospitalization. The opposite was also true, however; a patient was hospitalized when he exhibited relatively minor symptoms but there was no family able or willing to assume responsibility for him. Ambiguity of available information concerning the family situation was itself influential in the decision to admit.

ILLUSTRATION 26.
The patient, a 53 year old woman, was brought to the Acute Facility as a referral from another facility. She exhibited significant thought disassociation, a classical symptom of schizophrenia. The admitting resident indicated she had no insight at all, citing her statement, "If you take a drive in the city, you'll find lots of

people crazier than I am." Curiously, the patient had functioned in her employment up to the time of admission. Little information was available as to the patient's home situation. The patient maintained that she had to return home to take care of her daughters, but the admitting resident believed that three of her daughters were married and the fourth was engaged. She was admitted despite her objections. The resident indicated that he felt she might well have been able to remain in the community if some supporting person had been available, but he had concluded that no one was available.

Supporting resources, such as this patient lacked, may have been available in the community; but the patient may nevertheless have been admitted because these resources were disrupted or disturbed—in some cases by the patient's symptomatic behavior, although in others the relationship between the patient's illness and the disruption of the family was much less direct.

ILLUSTRATION 27.
The patient was a 38 year old woman who had been having severe marital difficulties. After receiving unexpected doctor bills, she took an overdose of sleeping medication and immediately informed her husband of what she had done. When, at the emergency room of a general hospital, she became abusive, she was taken to the Acute Facility. The resident, after determining that the dosage taken was not enough to be dangerous, was about to release her to "sleep it off." He indicated that he hospitalized her because the family was disrupted by the patient's insistence that she was unhappy with her marriage and desired to terminate it, and had been particularly shaken by the events of the evening. One son, the resident related, had been reported at home hiding in the bathroom from fright.

In these cases hospitalization of the patient was essentially a means of "treating" the family. The objective sought was not so much improvement of the patient's psychopathology as giving the family an opportunity to resolve as far as possible the temporary crisis that preceded the patient's presentation and to regroup itself in preparation for taking the patient back.

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In practice, then, it appeared that the legal criteria had almost no effect in limiting those who were admitted on a nonvoluntary basis. Although a patient who was considered a threat to himself or others may have been admitted for that reason, no attempt was made to limit nonvoluntary admissions to such situations. As Illustrations 19 and 24 show, patients who cannot be considered to meet the "dangerousness" criteria (under any reasonable definition of the meaning of that criteria) were nevertheless admitted. As Illustrations 23 and 27 demonstrate, even where an argument that the patient is within the criteria could have been made, it was frequently true that the reason for admission was not that the patient may have met the criteria.

D. *The Decision to Commit*

For a relatively small number of individuals, public psychiatric hospitalization also involved a decision by the probate court as to the justification for hospitalization. Procedurally, there are three ways in which an individual may come before the probate court: (1) having entered a hospital as a voluntary patient, he may give notice of intent to leave and the facility may then apply for his commitment as a nonvoluntary patient; (2) he may, after having been served with the notice required by the Missouri version of the standard nonjudicial procedure, request a judicial hearing; or, (3) direct application may simply have been made to the probate court for his commitment.

Table 4 shows the frequency with which the various procedural routes have been used since 1954.[80] The standard nonjudicial proce-

a certification. But where, as in certifications by resident physicians of the facility itself, the certifying physician is an agent of the facility, it seems impossible to separate his duty and that of the facility.

89. Because of the method of filing in the probate court, these tables do not accurately indicate the exact number of hearings held in each year. If an application is filed in regard to a patient who had been before the court in an earlier case, the newly filed case is placed with the earlier proceeding file. For this study only those files under the years indicated were examined; those files for nonexamined years, then, contained some cases that were in fact heard during the years studied. Of the 185 cases examined for 1967, for example, nine were found in files under the years 1955, 1957, 1959, 1961, 1963 and 1965. There is no reason to believe that the cases not considered were other than randomly distributed throughout the categories.

TABLE 4
JUDICIAL HEARINGS BY YEAR AND TYPE OF PROCEDURE

Year	Total Hearings	Direct Applications No.	Direct Applications %	Patient Request —Standard Nonjudicial Procedure No.	Patient Request —Standard Nonjudicial Procedure %	Application to Retain Voluntary Patient No.	Application to Retain Voluntary Patient %
1955	71	70	99	1	1	0	0
1957	180	173	96	2	1	5	3
1959	328	315	95	5	2	8	3
1961	382	371	97	3	1	8	2
1963	419	397	97	2	1	10	2
1965	232	225	97	4	2	2	1
1967	185	163	91	1	.5	16	8.5

dure, it appears, has been a relatively minor part of the process.[90] The most common procedural route to the court has been the direct application. But this designation is misleading insofar as it implies that it is a judicial proceeding brought to hospitalize an individual who is at the time in the community. Table 5 breaks down direct applications for the years studied by location of the respondents at the time notice of the proceeding was served. Never more than 2.7 per cent of the proceedings were begun before the patient had been hospitalized;[91] the overwhelming majority had already been hospitalized in the Acute Facility.

The primary function of the probate court, then, has been to au-

90. Extensive records were not available, but figures obtained from the Welfare Department indicated that in 1967 notices were served pursuant to the standard nonjudicial procedure in 104 cases. The location of the respondents at the time they were served was as follows:

public acute facility	73
private hospitals	24
State Hospital	6
at patient's home	1
Total	101

Apparently the general policy of the Acute Facility is to use the standard nonjudicial procedure only for those patients initially admitted on a voluntary basis but for whom longer term care is desired with a right to retain if necessary. Careful screening results in the use of this procedure only for those patients who are almost certain not to request a judicial hearing.

It is significant that, as the above figures show, even in the use of this procedure legal steps towards securing nonvoluntary hospitalization are almost never taken until hospitalization has already been effected. This strongly suggests that the basic dynamics of the process do not differ with the procedural route chosen to effectuate the decisions.

91. Most of those cases where legal action was taken before the individual was hospitalized involved either children living at home or elderly relatives.

TABLE 5
PATIENT STATUS PRIOR TO HEARING AND HEARING DISPOSITION, BY YEAR (DIRECT APPLICATIONS ONLY)

Year	Total Hearings	Patient Status (% of total)						Disposition (% of total)							
		Hospitalized			Home	Other		Dismissed			Committed				
		Acute Fac.	Other Public Fac.	Private Fac.				Patient dis-charged	Dismissed by Petitioner	Other reasons	Total	Public Fac.	Veteran Fac.	Private Fac.
1955	70	94	1.5	1.5	0.0	3.0		56.0	4.0	0.0	40.0	40.0	0.0	0.0
1957	173	94	0.0	3.0	2.0	1.0		35.8	4.6	0.0	59.6	57.2	0.6	1.2
1959	315	91.4	7.0	1.6	0.0	0.0		15.2	1.0	0.0	83.8	82.5	1.3	0.0
1961	371	96.8	1.6	0.8	0.8	0.0		11.9	1.9	0.0	86.3	83.6	1.9	0.8
1963	397	95.2	3.3	1.0	0.5	0.0		17.7	2.0	0.0	80.3	76.8	2.0	0.5
1965	225	89.4	5.3	1.8	2.7	0.9		26.6	3.1	0.0	70.3	66.7	3.1	0.5
1967	168	80.0	6.5	2.0	2.0	0.5		22.0	7.1	1.2	69.7	61.9	66.6	1.2

thorize continued retention of patients hospitalized pursuant to the emergency detention power. This function, moreover, has not been performed until after a significant period of hospitalization has already elapsed. Usually the hearing was held about three weeks after the patient's admission to the Acute Facility, although continuances (sometimes at the request of the Acute Facility itself, but more often on the motion of the court when witnesses failed to appear for a scheduled hearing) frequently lengthened this period.

Because of this time lapse between admission and hearing, the opportunity for a judicial hearing was as a practical matter extended to only about one-half of all patients admitted on a nonvoluntary basis. In 1967, there were approximately 500 patients admitted on a nonvoluntary basis. (This excludes those committed for pretrial study by criminal courts.) Yet, as Table 5 shows, hearings on applications submitted by the Acute Facility for commitment of patients already detained in the hospital amounted to less than half this number.

Table 5 also indicates that the number of cases in which applications for commitment have been filed has decreased from a peak of 397 in 1963 to 168 in 1967. This probably represents an increased emphasis on initial voluntary admissions as well as a more rapid turnover of patients stimulated by space pressures as well as a desire to minimize duration of hospitalization for therapeutic purposes.

In extremely few cases did the court dismiss applications on their merits. Only two of the 1,700 cases examined resulted in the patient's release. This suggests that further examination of the court proceedings may be fruitless. If applications for indeterminate commitment submitted by the Acute Facility were granted simply as a matter of course, the judicial hearing process was essentially nonfunctional. But observation of a number of hearings revealed that their form was much less perfunctory than the hearing observed in some other studies[92] and less than would be expected if the hearing was regarded by all concerned as merely a matter of form. This contrast between the form

92. Scheff, *Social Conditions for Rationality: How Urban and Rural Courts Deal with the Mentally Ill*, 7 BEHAVIORAL SCIENTIST 21 (1961), in MENTAL ILLNESS AND SOCIAL PROCESSES (T. Scheff ed. 1967), studied four urban courts in an unidentified state. Even in the one court in which Scheff felt some attempt was made during the hearing to ascertain the circumstances of the patient, he concluded that the court did not use the information gathered to make a meaningful decision as to disposition. This was based largely on his observation that in all 43 cases observed in this court (including some where there seemed to be a significant question whether the legal criteria was met) the court ordered hospitalization. *Cf.* Miller & Schwartz, *County Lunacy Commission Hearings: Some Observations of Commitments to a State Mental Hospital*, 14 SOC. PROB. 26 (1966).

of the hearing and its apparently minimal role in the overall process justifies a more detailed examination of the judicial hearing step, if only for the purpose of explaining this apparent discrepancy.

The following discussion is based on first hand observation of seventeen hearings. The basic observations are summarized in Table 6. The first column breaks the hearings down according to the source and nature of the principal demand for hospitalization. A case was characterized as "Family Demand Based on Desire for Treatment" if it appeared that the family desired the patient's hospitalization, had acted on that desire and the desire was based primarily upon a sincere concern for the patient's welfare. A case was characterized as "Family Demand Based on Rejection of Patient" if it appeared that the family had actively sought hospitalization of the patient primarily as a means of relieving itself of a disruptive influence. "Acute Facility Demand for Hospitalization" was used where no family had been actively involved in the hospitalization process, and consequently the primary demand for continued hospitalization came from the Acute Facility.

This breakdown suggests that families played a smaller role (quantitatively speaking) in obtaining long term hospitalization than they did in obtaining short term institutionalization. The family was influential in the presentation of about 75 per cent of the nonvoluntary admissions studied. Table 6, however, suggests that they were influential in only about 50 per cent of commitments. This can be explained in part at least by the successful performance of the "crisis solving" function by the Acute Facility; during a short period of hospitalization, the crisis situation that caused the family to seek the hospitalization of one of its members can often be resolved, thereby dissipating the demand for continued hospitalization. It is not surprising, therefore, that those patients for whom longer periods of hospitalization were sought were more frequently patients without a family group who could reabsorb them and for whom the demand for removal from the community came from "official" community agencies, initially the police in many cases and subsequently the Acute Facility.

Only about one-third of the patients actively appeared and protested their continued hospitalization. In most of these "resisters" cases the demand for hospitalization was made by the Acute Facility. This indicates that where a patient was a member of a family group and the family actively sought his hospitalization (either from concern for his welfare or for their own convenience), the patient frequently did not actively resist continued hospitalization, although he may have refused initially to admit himself on a voluntary basis.

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TABLE 6
SEVENTEEN OBSERVED COMMITMENT HEARINGS

Primary Demand for Continued Hospitalization	Total Cases	Symptoms Present: dangerous suicidal tendencies	assaultive tendencies	wandering	Diagnosis*: psychosis	neurosis	personality disorder	chronic brain syndrome	alcoholism	Patient Attitude: passive	resistive	not present	Disposition: commitment	dismissal
Family—														
based on desire for treatment	3	1	2	0	2	0	0	1	0	1	0	2	3	0
based on rejection of patient	6	0	3	3	1	0	1	2	0	1	2	3	6	0
Acute Facility	8	0	2	3	5	0	1	1	1	2	5	1	7	1
Total	17	1	7	3	8	0	2	4	1	4	7	6	16	1

* In two cases no diagnosis was offered.

Almost half of the patients were diagnosed as psychotic; all were either schizophrenic or manic depressive affective reaction. The psychotics tended to be patients where the demand for hospitalization was made by the Acute Facility. Where a family group was actively involved, this suggests, the demand for hospitalization was likely to arise from factors other than the degree of psychopathology; where, however, the decision was left largely to medical personnel, degree of psychopathology apparently played a more important role.

As both the court files and the firsthand observations indicated, dismissals were extremely rare. No meaningful statistical comparison can be made, therefore, between those cases resulting in commitment and those resulting in dismissals. But it is feasible to discuss in some detail the mechanics of the hearing procedure and the basic dispositional alternatives for the purposes of analyzing existing practice and investigating the potential for more active judicial involvement.

1. *The Hearing Mechanics*

The hearings were held in the probate court's regular courtroom on Monday and Thursday. Court was not convened until 10:00 a.m., but the patients usually arrived (accompanied by hospital attendants) about 9:30 a.m. Patients were not required to attend; they were notified by formal service at the hospital and on the morning of the hearing they were asked whether they desired to attend. Although in six out of the seventeen observed cases the patient did not attend, in only one case was any inquiry made into the reason for the patient's non-attendance.[93]

Also present prior to the opening of court was a local practicing attorney who by agreement with the court was assigned as counsel for all patients who did not have a privately retained attorney. He received ten dollars per case which was added to court costs. In only one observed case was a privately retained attorney present.[94] The repre-

93. In this case the inquiry was stimulated by the judge's recollection that when the patient had appeared in court a week earlier (at which time his hearing had been continued because a witness had failed to appear) he had indicated a desire to protest hospitalization. The inquiry revealed that the patient had not appeared because the Acute Facility, unaware of the continuance, had assumed that the patient had been committed and had not offered him the opportunity to leave the facility and appear in court.

94. This case provided no basis for confidence that involvement of privately retained counsel would make the judicial process more meaningful. The patient involved is described in Illustration 30, *infra*; whether she met the legal criteria is an extremely close [illegible] first hearing date, counsel appeared but the case was continued because

sentative of the city attorney's office, who presented the "case" for hospitalization, arrived about the same time. He brought with him the medical report, which was given to defense counsel for examination. The report was in the form of a deposition typed in a mimeographed form. On the front was a blank for the attorney for the patient to sign a waiver of personal appearance by the physician; in all cases it was routinely signed.

Between 9:30 and 10:00 the appointed attorney interviewed the patients. He generally asked them about events leading to their hospitalization and whether they desired to testify. When asked—and sometimes when no inquiry was made—he advised them that the court was unlikely to release them and that little good would probably be done by their testimony. There were usually two to five hearings per session; the attorney-patient interviews took about five minutes each. Sometimes the attorney would speak with family or friends who were present in the courtroom; the city attorney's representative almost always did.

At ten o'clock court was formally opened and the judge entered. He sat at the bench but did not wear a robe. As each case was called, the city attorney's representative called his witness.[95] When, as sometimes happened, a witness failed to respond to the subpoena the case was continued and the city attorney's representative directed to secure the witness's presence. During the continuance, of course, the patients remained hospitalized.

The witness, after being formally sworn by the judge, was initially questioned by the city attorney's representative. Questions were usually asked about the patient's life, his residence, events leading to his hospitalization and factual matters alluded to in the medical report (such as violent conduct by the patient). Frequently the witness was asked if he believed the patient needed further treatment or if he was willing for the patient to remain in the hospital. Counsel for the patient had an opportunity to cross-examine but this was seldom done. The court itself also usually questioned the witness; in many cases

present), counsel did not appear and the case was again continued. At the third date, both counsel and the patient's father appeared. Counsel was shown the medical report (which he had not seen before) and spent about five minutes reading it. During the testimony he asked a few questions of no significance. This was the extent of his participation.

95. The court usually required one witness in each case. If the patient had a local family or close friend, a member of the family or the friend was usually called. If the patient was a transient, a member of the facility staff (usually a social worker) was called. A shorthand transcript of the proceeding was always taken.

most of the detailed information was elicited by the court rather than by counsel. The same procedure was used by defense counsel in calling the patient. In none of the observed cases was any witness other than the patient himself called on the patient's behalf, nor was any other evidence submitted in support of the patient's case. The hearings lasted from ten to forty minutes.

At the end of the hearings, the judge took one of three steps: he indicated to the patient that he would order him discharged; he indicated that he would enter an order committing the patient; or, he took the case under submission, indicating that he would seek further information from the hospital. Each of these deserves special examination.

2. *Results of Hearings*

a. Commitment. Sixteen of the seventeen observed cases resulted in indeterminate commitment of the patient. According to the statutory criteria, such a disposition required factual showings of mental illness and that by reason of this illness the patient was dangerous to himself or others or lacked the insight or capacity to make responsible decisions with respect to his hospitalization. In the cases observed, however, these did not appear to be the governing factors.

Relatively little attention was directed towards dangerousness. As Table 6 shows, in only one case was there any indication of potential for self-inflicted violence; in this case, the patient's mother had found him almost entirely out of an eleventh story window. Six cases contained some indication that there was a danger of assaultive conduct; in all six, this was based upon the past acts or threats of the patient. There was, however, little detailed investigation of the factual allegations. In one case, for example, the medical report contained the mere assertion that the patient had "threatened hospital personnel"; the patient did not appear at the hearing and no investigation as to the truth of the assertion or its seriousness was made. In another case, the minimal factual investigation revealed a significant dispute as to the factual basis for the allegation of dangerousness.

ILLUSTRATION 28.
The medical report asserted that the patient had "jumped on his sister's son with intention to do great bodily harm." The patient's mother (who agreed that her son was sick and needed hospitalization) denied that the patient had ever assaulted or even threatened her grandchild. (The medical report also stated, "He

remains withdrawn, suspicious, guarded, antisocial, hostile, defiant and it seems he is dangerous to himself or others.")

It is doubtful whether past acts of an assaultive nature or threats of such actions were controlling in the decision to commit even in those cases in which they existed. In some, the assaultive actions seemed to be more disruptive of family harmony than such as to create a danger of serious physical injury.

ILLUSTRATION 29.
The patient, who lived with her sister's family, reportedly threatened the members of the family. On the morning of her presentation to the Acute Facility, she threw a cup of hot coffee on her sister; this stimulated her presentation.

The relatively minor impact of assaultive tendencies which have not had serious results can be easily seen in the following illustration. Although both acts of violence and threats had occurred, they played only a minimal role in the patient's presentation, admission, and commitment.

ILLUSTRATION 30.
The patient was a young woman who had voluntarily entered the Acute Facility but subsequently demanded her release. The medical report stated:

> The patient came to the emergency room . . . and was diagnosed as Anxiety Reaction. The patient went to New York . . . and lived there for three years. Her father went after her because he stated the patient had a nervous breakdown. No other factors are known. The patient was [previously] in . . . [a local private hospital] and received shock treatments. After her discharge she refused to go to the clinic and returned to New York. She called her father for money to pay her hotel bills while in New York. . . . [S]he came back to St. Louis but did not work. She made trips to Chicago and Detroit and kept calling her father for money. She lived in [an apartment hotel] . . . and when asked to pay the rent would cry. The patient had threatened to kill her sister and her brother-in-law. She had been moody, having nightmares, will sit and stare, will not talk and says she hates everybody.
> The patient . . . refused to answer any questions and showed poor insight into her problems. Her affect was shallow but there was no evidence of hallucinations and no evidence of delusions could be brought out . . . . The patient remains hostile, unfriendly and uncooperative.

At the hearing the patient's father testified. He indicated obvious concern over the inconvenience and expense of getting the patient back to St. Louis after her trips. He also testified that he "had been told" that the patient had threatened to take her brother-in-law's gun and shoot his family (with whom she lived at the time) and to burn their house down. He also stated that she had once violently resisted the family's attempts to force her into a car to go to a psychiatric outpatient clinic. The patient's employment history was irregular; the father testified that he had been told that there were few hospitals in New York City where the patient had not worked.

The patient herself testified that she felt that she did not need further full time hospitalization and that she could—and would—take outpatient treatment. She emphatically indicated that she did not want additional electroshock treatments. When asked about her plans regarding what she would do if released, she was vague. She was not asked about the alleged threats to her brother-in-law's family, nor was any inquiry into her employment history made. The court ordered her committed.

In three of the six cases, the patient had at least once left the family and subsequently requested help when difficulties arose; the patient in Illustration 30 was one example. All three were cases where the family had rejected the patient; the "wandering" tendency was undoubtedly a factor in the rejection. This graphically illustrates the extent to which the "need" for hospitalization depended on factors external to the patient: the tendency to wander can be realistically said to create a danger only if the family is or becomes unwilling to lend assistance.

In five of the sixteen cases in which commitment was ordered, there was no specific indication of "dangerousness" within any reasonable definition of that criteria. Some contained evidence of serious psychopathology which might have so distorted the patients' mental processes as to bring them within the category of those lacking sufficient insight or capacity to make responsible decisions with regard to hospitalization.

ILLUSTRATION 31.
The patient, diagnosed as manic depressive (depressed type) had exhibited auditory hallucinations and was treated on an outpatient basis. The medical report indicated that on her last appointment it was decided to hospitalize her "in an effort to speed her recovery"; no details or explanation were given. The "voices" spoke against hospitalization and the patient refused to admit herself. She was admitted on a nonvoluntary basis. At the staffing, three days after admission, it was concluded that she had lost her insight. (She at that time believed she was another Christ risen

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from the dead.) But at the time of the application for commitment, the report indicated, she had "begun to develop insight again." The patient's sister testified that she did not believe the patient needed hospitalization. The patient herself (who was classified as a "resister") testified that she went to the clinic because she was sick and wanted to get well but she felt she received no real treatment in the hospital. She indicated that she considered herself ready to go home and, if this were permitted, would take medication on an outpatient basis.

There was, therefore, at the time of the hearing no indication that the patient did not acknowledge that she was "sick" and that she would faithfully make use of outpatient facilities. (This, of course, was strong evidence of "insight.") On the other hand, it seemed clear that she had made a rational decision to accept treatment only on an outpatient basis and there was no proof that this would be either unsuccessful (or even less successful than hospitalization) or dangerous to the patient or others. No effort was made at the hearing to resolve these problems.

In some cases commitment was ordered where there was neither evidence of dangerousness nor a diagnosis of serious psychopathology. Apparently the basis for commitment was that even the minor degree of psychopathology diagnosed had caused the patient significant difficulty in adjustment to the inevitable problems of everyday living.

ILLUSTRATION 32.
The patient, a woman in her early thirties, had been deserted by her husband and left without support for herself and her eleven year old child. She had, however, been receiving welfare payments. About three and one-half years ago, according to the medical report, she "became ill in a major way as she became increasingly suspicious, interrupted her employer, lived a life of a recluse and severed all family contacts." Admitted at this time to the Acute Facility, she was given electroshock treatments and discharged.

The present crisis occurred when the patient went to see her son's teacher and "something happened." The patient testified that because of her recent shock treatment she could not remember the event; apparently neither the family nor hospital personnel had investigated. The patient's mother testified that following the "event" school authorities took the child and gave it to the father, while the patient's sisters took the patient to a local private hospital. (The medical report, however, stated that she was admitted to the private hospital because "she was given to wandering, neglecting her child and relating to her family in a very markedly paranoid way.") Her legal status at the private hospital was unclear; she was, however, given electroshock treatments there. Because of the cost of the private facility, she was transferred to State Hospital. She refused to sign an application for voluntary admission "on the ground that she was not sick." The State Hospital applied for her commitment.

The medical report diagnosed her as "personality pattern disturbance, paranoid personality" and noted a history of psychopathology in her mother's family. The report concluded, "All of the facilities of the hospital were used in order to rehabilitate her, but it became evident that the patient was not going to be mobilized in a short period of time." A social history report filed with the court indicated that the patient's husband had left her to live with another woman and that the patient's attitude towards her family arose from the fact that the patient resented the fact that she was illegitimate and feared that this would be disclosed.

The testimony of the patient's mother added little. She suggested that the prior admission to the Acute Facility followed a criminal charge of assault which arose out of a dispute the patient had with neighbors over a clothesline. The patient herself testified that she felt capable of leaving the hospital and could get along if she could find a job. She was questioned by the court as to whether she had many close friends (which she indicated she did not) and the amounts she had received from welfare payments. There was no indication of disorientation or disruption of the patient's mental processes. She was ordered committed.[96]

b. Dismissals. In only one of the observed cases did the court dismiss on its merits an application for hospitalization. In this case, it was clear that the patient had sustained organic brain damage but it was equally clear that this affected his behavior only to a minimal extent.

ILLUSTRATION 33.
The patient, according to the medical report, had been brought to the Acute Facility by the police because "a confusional state was suspected." While at the Acute Facility he had several seizures

96. Whitmore, *Comments on a Draft Act for the Hospitalization of the Mentally Ill*, 19 GEO. WASH. L. REV. 512, 522-23 (1951) criticized the Draft Act's criteria on the basis that patients diagnosed as neurotics would be subject to hospitalization under the "sufficient insight" criteria. Ross, *Committment of the Mentally Ill: Problems of Law and Policy*, 57 MICH. L. REV. 945, 959 (1959) responded that the "sufficient insight" criteria was meant for *psychotic* individuals whose condition had not yet created a danger to the patient or others but which would in the future; neurotic individuals, he asserted, would be subject to hospitalization only if they met the dangerousness criteria. This study indicates, however, that as the Draft Act criteria is applied in St. Louis, individuals suffering from only a personality disorder (a lesser degree of psychopathology than neurosis or psychosis) who do not meet the dangerousness criteria are in fact subjected to nonvoluntary hospitalization.

and was treated with phenobarbital. Diagnosis was chronic brain syndrome, "chronic alcoholism (by history)" and "convulsive disorder (etiology unknown)." In the medical report the patient was described as

> cooperative and friendly. He has dull facial expression, his mood was well modulated, with no thought disorder, no delusions, or hallucinations . . . He was oriented to place and person but disoriented to time. His memory for past events was . . . [*sic*] with marked fluctuation and was fair for recent events, attention and concentration were poor. Patient was poor in arithmetic and general information, highly concrete on proverbs; insight and judgment fair.

At the hearing the patient testified that he lived with his cousin and his wife. He could not remember being taken to the hospital but attributed this to one of the "fits" he had experienced. These "fits," he testified, had not interfered with his work and his car washing job (which he had held for a number of years) was being held open for him. The patient admitted an earlier "drinking problem" but maintained that he had stopped drinking two years ago because of his health. The other witness was the patient's cousin's wife who confirmed the patient's work history and indicated that there was no objection to the patient returning to her home if he were released.

Commenting that "There is no reason to hold this man," the court indicated that it would order him released.

c. Submissions. In three of the observed cases no disposition was made at the time of the hearing. Rather, the case was taken "under submission" and the court took informal steps to secure additional information. Commitment was ultimately ordered in all three cases. Nevertheless, all three represented situations where the court recognized that the hearing procedure did not disclose sufficient information on which to base a disposition and where specific attempts to engage in further fact-finding were made.

ILLUSTRATION 34.
The patient, an elderly but large man, had been taken to the Acute Facility by police upon the request of his wife. He was diagnosed as "highly suspected chronic brain syndrome, mild" and the medical report indicated:

> The patient's wife states that her husband would accuse her of dating a man and then he would beat her. She stated that this had been happening for about a year. We are still unable to determine whether the patient is delusional in regard to his wife or whether she is really being unfaithful to him. Social Service is in the process of investigation . . . .

At the hearing the patient's wife testified that she knew nothing about the men that the patient had accused her of dating. She also reported that the patient had exhibited other abnormal behavior; he had refused to sleep with the lights off and accused her of leaving the house door open so that "someone" could get in to kill him so she could collect his insurance and he occasionally "saw things." The patient testified that he had observed his wife with other men, had merely left the television lamp on on several occasions and denied any hallucinations. Upon being questioned by the court, he admitted striking his wife once on each of two occasions; the first, he testified, involved her failure to prepare a meal for the children and was unrelated to her unfaithfulness. The court indicated to the patient that unless the hospital had some evidence that his beliefs were not factually true, release would be ordered.

The court phoned the Acute Facility resident in charge of the patient's ward and also spoke with the supervising staff psychiatrist. Nine days after the hearing, a supplemental medical report containing the following was filed:

> The ministers, neighbors and children were approached by the facility's social service staff. No definite information could be obtained that the wife was stepping out of the home with other men.
>
> . . . .
>
> The patient could be dangerous to his wife due to the fact that he responds to his delusions, which are highly systematized and fixed. The patient is being treated with Thorazine . . . and Stelazin . . . So far there has been no change in the patient's belief. After a certain period on the drugs, electroshock therapy might be considered and if there is no change there is a possibility of the patient being transferred to State because the patient will be a risk to his wife's safety and well-being if released.

Ten days later, according to a note in the case file, the court again phoned the supervising staff psychiatrist and was assured that "it is not simply the protection of the wife that motivates them to retain the patient, but that the patient actually needs custodial treatment for a mental condition." On that date, an order commiting the patient was entered.[97]

97. A similar informal method of gathering information was condemned in *In re* Leary's Appeal, 272 Minn. 34, 136 N.W.2d 552 (1965). After the hearing on an application for commitment, the superintendent of the facility visited the trial judge in chambers and related "some information as to the day to day observations of the patient during the time that she was in the institution." Although it concluded that this was not sufficient basis to reverse the commitment, the Minnesota Supreme Court commented that it was "convinced that it was not proper to consult with . . . [the superintendent] in the absence

3. *Analysis*

Several general observations can be made regarding the judicial commitment process. A great deal of emphasis was placed upon forms of procedural fairness: assignment of counsel, availability of witnesses, direct and cross examination of witnesses, and even, to a lesser extent, the rules of evidence. But far from all of those involuntarily hospitalized were ever afforded whatever opportunity to avoid hospitalization this provided. Because of the three week delay between admission and hearing, many patients had, by the time scheduled for the hearing, been released. In addition, if a patient was still detained at the time of the hearing, the judicial procedure offered him little substantive protection. The criteria applied by the court was not that laboriously set out in the statute. Commitment was ordered if the court believed, on the basis of assertions in the medical report, that the Acute Facility had some basis for concluding that the patient was "mentally ill" (as the facility chose to define that term) and that as a result of this illness the patient had experienced some difficulty in living.[98] No attempt was made to resolve many of the factual issues that arose, even where these appeared to be determinative.

The implications of these observations, when considered in light of

of appellant or her counsel. Appellant had a right to cross examine the doctor on any information conveyed to the court that might influence his determination." 272 Minn. at 44, 136 N.W.2d at 558. *See also* Holm v. State, 401 P.2d 740 (1965), holding that the trial court in a commitment proceeding erred in permitting the jury to inspect the court file which contained a medical report. A statutory provision (adopted from the Draft Act) relied upon by the appellee provided that the court in a commitment proceeding "shall not be bound by the rules of evidence"; this was held unconstitutional as a violation of the judiciary's inherent power to control the course of litigation as well as the appellant's right to hear and controvert all evidence upon which factual determinations are to be made. *Cf.* People v. Dykema, 89 Ill. App. 2d 409, 232 N.E.2d 471 (1967).

98. *Cf.* the conclusions of Miller & Schwartz, *County Lunacy Commission Hearings: Some Observations of Commitments to a State Mental Hospital*, 14 Soc. Prob. 26 (1966). 58 hearings, averaging 4.4 minutes each, were observed; thirteen resulted in release of the patient. As to the decisional criteria, the study concluded:

> [T]hose persons who were able to approach the judge in a controlled manner, use proper eye contact, sentence structure, posture, etc., and who presented their stories without excessive emotional response or blandness and with proper demeanor, were able to obtain the decision they wanted . . . despite any "psychiatric symptomatology."

Id. at 34. Yet, the study suggests, this criteria was not altogether inappropriate: it can be argued that those patients who were unable to present the appearance demanded by the court lacked "social acumen and awareness" and that this (whether or not it was technically a symptom of their illness) demonstrated that they would encounter difficulty living in the community. Assuming this to be true, however, neither the criteria applied in St. Louis nor that apparently applied in the hearings observed in the Miller-Schwartz study had any relationship to the formal legal criteria for nonvoluntary hospitalization.

the preceding steps in the hospitalization process, are clear. Although the statutory framework assumed that the operation of the system would be controlled by the legal criteria and that the criteria would be applied by a judicial body, this has not been the case. The criteria actually used has been much broader than that set out in the statute and has been applied by the Acute Facility itself (subject to very limited review by the probate court *if* the facility decided to retain a patient longer than three weeks). Despite the strict observance of the form of effectiveness, the judicial commitment procedure was in reality practically functionless in the hospitalization process.

E. *The Hospitalization Process: An Overall Analysis*

This study had demonstrated that nonvoluntary hospitalization in the St. Louis public Acute Facility is the result of decisions by a series of decision-makers: the community's decision to present, the facility's decision to admit, and, in a few cases, the probate court's decision to commit. Each decision influences the next—the fact of presentation influences the facility to admit, and the fact of admission influences the court to commit. The procedural sequence of events is far different from that anticipated by the legal framework. In almost none of the cases is the initial decision to coerce the patient for treatment purposes made by the court. In almost all the initial decision is made in the community; the next decision is frequently that by the facility to admit and retain. Only after these decisions have been made and effectuated does the court have the opportunity to decide whether or not to authorize continued nonvoluntary detention.

But the fact that all (or the most important) decisions are not made judicially does not mean that they are made in violation of the criteria set out in the legal framework. Even if the criteria actually applied at a given stage does not correspond to that in the legal framework, this does not necessarily mean that the system is at that point exceeding its theoretical authority. It is possible that from among those who meet the general criteria of the legal framework, the system, its capacity limited by facility and personnel shortages, selects only a limited number for inclusion within its program. This would be the situation if the criteria actually applied was included within that proscribed by the framework or if it was applied only to those who also meet the statutory criteria, i.e., if the actual criteria included the requisites of the statutory criteria or if prior to the application of the actual criteria all those not meeting the statutory criteria had been screened out. If either is

the situation, the legal framework could be considered as establishing an outer boundary defining those who *may* be subjected to the system. As among those within this boundary, the system can be considered free to select for actual inclusion on some basis other than the criteria set out in the legal framework.

The study, however, suggests that not only does the criteria applied at all three decision-making points not correspond to that set out in the legal framework, but also that the criteria actually applied is *broader* than that proscribed by the legal framework. Nor is there any preliminary screening process assuring that this broad criteria is applied only to those who meet the statutory criteria. The techniques used in the study are not sufficiently precise to permit a reliable estimate as to the total number of patients presented, admitted or committed who did not come within the boundary defined by the statutory criteria. There is no doubt, however, but that on a day-to-day basis the acute psychiatric treatment system exceeds its legal authority to detain individuals for treatment purposes.[99]

99. A breakdown of admissions by race and sex also permits some interesting speculation. At the time of the 1960 census the city was 28.8 per cent Negro; as Table A indicates, the admissions studied were 23 per cent Negro. This provides some—but little—support for the assertion that public mental health facilities underserve the nonwhite population. Although female patients tended more than male patients to have been nonvoluntary admissions, the variation was not large.

TABLE A
ADMISSIONS BY TYPE, RACE AND SEX

	Race			Sex	
	White	Negro	Unidentified	Male	Female
All Admissions	67%	20%	13%	53%	47%
Voluntary Admissions Only	75	14	11	57	43
Nonvoluntary Admissions only	53	29	18	47	53

A more significant difference is apparent when admissions are considered by type and race. Voluntary admissions were significantly more often White patients than were nonvoluntary admissions; nonvoluntary admissions contained more than its proportionate share of Negro patients. Several factors may account for this. The city's Negroes may, as a group, have less "psychiatric sophistication" than Whites and consequently they may voluntarily seek help less frequently for what they regard as illness. Or, psychiatric hospitalization may be more frequently invoked by others as a control device.

Both hypotheses are supported by Table B, which breaks down types of presentations by race. Identified Negro patients tended more than White patients to have been Police Presentations. *None* of the identified Negro patients had presented themselves. This suggests, then, that Negro patients were not presented because they recognized in themselves symptoms of illness but rather tended to have been presented under coercion and following precipitating situations that disrupted either the family or the community.

Why is the legal framework such a minor determinative of the actual operations of the system, both in terms of the content of the substantive criteria and the procedure by which it is applied? The most effective decision-making point was quite clearly the Acute Facility. Why had the court such a minor role in the overall process? Cause and effect are difficult to separate. Several possible explanations are more likely effects than causes of the minor role of the court.[100] For example, the court was not presented with a decision as to whether "to treat or not," but rather whether to authorize continuation of a course of treatment that has already been administered for several weeks. Thus the alternatives were unequally weighted. Release, which meant reversing a prior decision by the Acute Facility and discarding the potential value of three weeks of "therapy," was much less attractive than its alternative, especially in view of the general shortage of public psychiatric services. But this does not explain why the court did not attempt to become active at an earlier point in the process and thus minimize this factor. Consider also the obvious difficulty that the court encountered in obtaining factual information on which to make decisions which might be offered to explain its role. But this does not explain why the court did

TABLE B
PRESENTATIONS BY TYPE AND RACE

	White	Negro	Unidentified	Total
All Admissions	67%	20%	13%	100%
Self Presentations	90	0	10	100
Police Only Presentations	44	44	12	100
Family and Police Presentations	62	25	13	100
Family Only Presentations	60	20	20	100

100. Scheff, *Social Conditions for Rationality: How Urban and Rural Courts Deal with the Mentally Ill*, 7 AMERICAN BEHAVIORAL SCIENTIST 21 (1961), MENTAL ILLNESS AND SOCIAL PROCESSES (T. Scheff ed. 1967), reported that court commitment procedures tended to be more functional in rural than in urban courts. He attributed this to several factors: (1) the high volume of cases in urban courts, (2) stronger "political" pressures on urban judges to retain persons whom subsequent events might prove should have been retained (as, for example, newspaper coverage of a crime committed by a released patient), (3) the greater personal familiarity of the rural judges with the situations brought before them, (4) the greater psychiatric sophistication of the urban judges, which tended to encourage them to seek "treatment" and to rely on the facilities to determine "need for treatment," and (5) the tendency of the rural patient to be more articulate and to have a greater awareness of his legal rights.

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not take steps to obtain more information, such as requiring personal appearances of medical personnel in close cases.

Most likely, the distribution of effective decision-making authority was the result of general acceptance of what might be called a clinical concept of mental illness and the need for hospitalization. This approach holds that the "need" for psychiatric hospitalization is based upon the severity of clinical symptoms; existence of such need, it follows, is best determined by medical experts. But, as this study has shown, the clinical approach frequently does not correspond to the actual dynamics of the process. A symptom's significance lies largely in how it affects the patient's relationship to his environment. "Dangerousness," for example, is a combination of predictions as to how the patient will respond to certain situations (based to some extent on clinical symptoms), the likelihood of those situations arising and such other factors as the probability that specific persons may be present when they arise. There is some indication that a judicial decision maker may even be able to make a *more* accurate determination as to the need for hospitalization, even when the "need" is defined in terms of the patient's ability to live adequately in the community.[101] Nevertheless, the court with jurisdiction over the system examined here seems to have accepted the "clinical approach" and it appears that this is the most important determinative of the allocation of real authority in the hospitalization process.

While this may help to explain the failure of the court to take a more active part in the decision-making process, it does not explain why the legal criteria was not more closely followed by whoever exercised the actual authority. The answer to this question probably lies in the wide gap between the role envisioned for the psychiatric hospitalization system in the legal framework and that actually demanded of it by the community. The attempt to impose upon the system the criteria carefully set out in the legal framework constituted an attempt

101. Rappeport, Lassen & Gruenwald, *Evaluation and Followup of Hospital Patients Who Had Sanity Hearings*, 118 AM. J. PSYCHIATRY 1078 (1962), in THE CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL 81 (J. Rappeport ed. 1967), reports a study of 73 patients who had court hearings (at their own request) to determine the appropriateness of their continued hospitalization. Twenty-six were released by the court; of the remaining 47, ten were later discharged by the hospital and eleven escaped. A followup study of the 47 patients released by the three methods showed that although 44 per cent of those discharged by the court had a "satisfactory adjustment" to the community, only 30 per cent of those discharged by the hospital had adjusted satisfactorily. 42 per cent of the escapees had adjusted satisfactorily. The implication, as the study recognizes, is that "the hospital is unable to prognosticate significantly better than the court." *Id.* at 88.

to define the role that the psychiatric hospitalization system would perform in the overall business of keeping society in operation. If the prescribed criteria were effectively implemented, the psychiatric hospitalization system would serve the relatively limited functions of protecting the community from reasonably imminent physical assaults by the mentally ill, of protecting the mentally ill from self-inflicted harm or from situations which, because of their affliction, created a risk to their physical safety that was greatly in excess of that normally endured by members of the community, and of making the decision to obtain treatment for those mentally ill persons whose thought processes had been severely impaired by their illness. The fundamental error in this approach, of course, was in making the underlying assumption that this function could be controlled by legal fiat, i.e., the assumption that the psychiatric hospitalization system was controlled by the legal framework within which it in theory operated, and consequently that the operation of the system could be altered by simple manipulation of the legal framework.

The criminal justice system has been compared to the natural system of a biological cell;[102] the same comparison can be made with regard to the psychiatric hospitalization system. As is true of a single cell composing one part of a multi-cellular organism, the psychiatric hospitalization's internal operation is determined largely by its relationship to other aspects of the entire social organization of which it is a part. Specific aspects of the system's internal processes, in other words, are determined by the system's function as one part of a larger system, which in turn is determined by demands made upon the system by other parts of the larger system. In the case of the psychiatric hospitalization system, the legal framework is only one of those demands. Other demands from other sources are often of a more pressing nature in the day to day operation of the system: disrupted families demand hospitalization of one member as a means of "crisis remission"; neighbors demand hospitalization of irritating neighborhood "nuts"; police (and other participants in the criminal justice system) demand hospitalization of those considered dangerous or troublesome but who for some reason are deemed inappropriate subjects for the criminal system; physicians demand hospitalization when this is seen as a means of alleviating the suffering of an individual or family. Where there is no readily available alternative means of satisfying these demands, those upon whom the demands are made will, if possible, use the flexibility

102. D. OAKS & W. LEHMAN, A CRIMINAL JUSTICE SYSTEM AND THE INDIGENT 185-88 (1968).

in the resources available to them to satisfy the demands as best they can. Attempted revisions which neither eliminate the flexibility (which is probably impossible) nor alter the demands are unlikely to have significant effects. As a recent study of changes in juvenile court procedure observed, "Formal structure and procedure can be changed . . . but . . . old ends persist and continue to be satisfied."[103] An attempt to alter the function of a system such as the psychiatric hospitalization system by simply enacting a restrictive criteria and inserting in the system a judicial officer with directions to apply that criteria was destined in advance to failure.

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