

# Involuntary Civil Commitment as Mass Incarceration

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## INTRODUCTION

Involuntary civil commitment in the United States is a legal intervention by which a judge may order that a person whom the judge believes is demonstrating symptoms of a serious mental disorder, and meeting other specified criteria, be confined in order to receive treatment for this disorder for some period of time.<sup>1</sup> Involuntary commitment lies at the intersection of public health and the criminal legal system, acting as a “healthcare-to-prison pipeline” that further exacerbates racial disparities and reinforces white supremacy. The systems, structures, practices, and policies of structural oppression as seen through the exercise of involuntary commitment increase the power of the carceral state and further infringe on the liberty of individuals and communities to address behavioral and mental health crises without involving the police.

### I. INVOLUNTARY CIVIL COMMITMENT

The law surrounding civil commitment has traditionally been based on two distinct but equally important sources of state power: the state acting as *parens patriae* (“parent of the country”) in caring for the individual and the state acting through its police power in protecting society.<sup>2</sup> Although dangerousness to self or others is the most common basis for commitment, many states permit commitment in other contexts such as an inability to care for oneself. Depending on the state, the permitted maximum duration of treatment ranges from less than one month to more than one year for both initial and subsequent civil commitment orders.<sup>3</sup> Hearings for involuntary civil commitments have been described as a “charade” with the average length of the hearing ranging from 4 to 9 minutes long.<sup>4</sup> An involuntary civil com-

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1 United States Substance Abuse and Mental Health Services Administration (SAMHSA), *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*, 1 (2019).

2 Jonathan Cantarero, *The Ethics of Civil Commitment*, 16 J. OF HEALTH AND BIOMEDICAL L. 105, 111 (2020).

3 Paul P. Christopher et al., *Nature and Utilization of Civil Commitment for Substance Abuse in the United States*, 43 THE J. OF THE AM. ACAD. OF PSYCHIATRY & THE L. 313, 313 (2015).

4 Michael L. Perlin, “Who Will Judge the Many When the Game is Through?”: Consider-

mitment hearing must be held within some number of hours or days after commencement of custody. Not every state requires a hearing, however. In New York, hearings are held only upon request. Individuals who are medically certified for admission may be held for up to 60 days without any court order, although they are assigned legal counsel and may request a hearing at any time.<sup>5</sup> Retention beyond 60 days must be authorized by a court, but no hearing need be held unless requested.<sup>6</sup>

Although often overlooked, confinement in a mental health institution can actually be more severe than the criminal penalty one would receive for similar misconduct.<sup>7</sup> Thus, some argue that commitment should be used as a last resort when judges and doctors are extremely confident that commitment is the only viable option, and states should implement a constitutional limitation on the length of confinement prior to a rehearing.<sup>8</sup> This would allow individuals who are facing liberty and property deprivations due to mental illness the ability to receive—at a *minimum*—similar protections as those who face such deprivations through the criminal legal system.<sup>9</sup>

### **A. Challenges to Public Tracking of Civil Commitment**

It is difficult to determine both the scope and frequency of the use of involuntary civil commitment due to several complications including “patient privacy concerns, decentralized systems of mental health care, and variable commitment criteria across jurisdictions.”<sup>10</sup> In 1976, George Dix published an article that identified that “vigorous legal scrutiny of systems for involuntary treatment of mental illness has created an increased need for information from the behavioral sciences. Unfortunately, little such information is available.”<sup>11</sup> Almost half a century later this is still the case as there is little to

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*ing the Profound Differences Between Mental Health Courts and “Traditional” Involuntary Civil Commitment Courts*, 41 SEATTLE U. L. REV. 937, 937 (2018).

<sup>5</sup> SAMHSHA, *supra* note 1, at 12.

<sup>6</sup> *Id.*

<sup>7</sup> Samantha M. Caspar & Artem M. Joukov, *Worse than Punishment: How the Involuntary Commitment of*

*Persons with Mental Illness Violates the United States Constitution*, 47 HASTINGS CON.

L.Q. 499, 501

(2020).

<sup>8</sup> *Id.*

<sup>9</sup> NY Mental Hygiene Law, §9.33

<sup>10</sup> Nathaniel P. Morris, *Detention Without Data: Public Tracking of Civil Commitment*, 71 PSYCHIATRIC SERVICES 741, 741 (2020).

<sup>11</sup> George E. Dix, “Civil” Commitment of the Mentally III and the Need for Data on the Prediction of Dangerousness, 19 AM. BEHAV. SCIENTIST 318, 318 (1976).

no aggregation of national statistics relating to civil commitment.<sup>12</sup>

In 2019, Gi Lee and David Cohen shared that “the number of people detained nationally has never been reliably estimated” and used what scarce information was available to extrapolate that there are more than *one million* instances of civil commitment every year.<sup>13</sup> These researchers later published an article in 2021 which found that the most recent and complete set of data on emergency detentions in the US was from 2014 and based on 24 states.<sup>14</sup> During that year, those 24 states (representing 51.9% of the US population) reported 591,402 detentions.<sup>15</sup> This can be extrapolated to for the entire US population which is notably close to the one million estimate in 2014.

Regardless of how accurate this estimate is, there is no publicly available federal data on civil commitment and no evidence that the federal government is even tracking it. A 2016 study by Leslie C. Hedman notes that an analysis of civil commitment interventions “depend[s] on several factors: the statutory criteria and their application, the accuracy of the process for triggering an emergency hold . . . and the relationship of holds and hold procedures to health and treatment outcomes. There is little research aimed at measuring these factors.”<sup>16</sup> Notably, the federal government and all states gather and publish at least some data related to arrests and incarceration.<sup>17</sup> At the federal level, this data also includes “distributions of prisoner age, sex, race-ethnicity, location, citizenship, and offense characteristics.”<sup>18</sup> Despite civil commitment often mirroring—and sometimes substituting for—incarceration, there is almost no data in comparison. One article explains this by suggesting that the “discretionary rather than mandatory nature of commitment laws . . . reflects society’s ambivalence toward coerced care” and this ambivalence extends to a failure of the state to gather any meaningful data about whom they are detaining.<sup>19</sup>

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12 See, e.g., Morris, *supra* note 10.

13 Gi Lee & David Cohen, *How Many People Are Subjected to Involuntary Psychiatric Detention in the U.S.? First Verifiable Population Estimates of Civil Commitment*, Society for Social Work and Research 23rd Annual Conference, San Francisco (Jan. 18, 2019).

14 Gi Lee & David Cohen, *Incidences of Involuntary Psychiatric Detentions in 25 U.S. States*, 72 *PSYCHIATRIC SERVICES* 61, 63 (2021).

15 *Id.*

16 Leslie C. Hedman et al., *State Laws on Emergency Holds for Mental Health Stabilization*, 67 *PSYCHIATRIC SERVICES* 529, 532 (2016).

17 Morris, *supra* note 10, at 743.

18 *Id.*

19 Lee & Cohen, *supra* note 13, at 66.

**B. Quality of Counsel at Traditional Civil Commitment Hearings**

The lack of accountability after civil commitment takes place as evidenced by the insufficient collection of data is also present *during* civil commitment proceedings in the form of inadequate counsel. Michael L. Perlin notes that empirical research demonstrates that “most lawyers prepared much less for civil commitment cases than for other cases, many did not speak to clients before the hearing, and they rarely took an adversary role to obtain release of their clients whom psychiatrists had recommended for commitment.”<sup>20</sup> Counsel is often described as “woefully inadequate . . . disinterested, uninformed, roleless, and often hostile.”<sup>21</sup> In addition to the effect this has on their clients, ineffective counsel also results in a diminished amount of case law because few civil commitment cases are taken to trial. For example, Virginia has a slightly larger population than Minnesota, yet Virginia has ~98% fewer published and litigated cases on questions of mental hospitalization; one possible explanation is that, unlike Virginia, Minnesota “has a tradition of providing vigorous counsel to persons with mental disabilities.”<sup>22</sup>

On the other side of the bench, judges are described as having “little judicial experience and little incentive to develop expertise in this area” which conveys that “patients’ rights . . . are not important.”<sup>23</sup> One study identified that “fewer than one-third of judges told patients of their right to counsel, fewer than one-fourth told patients of their right to voluntary status, and about two-fifths told patients of their right to appeal.”<sup>24</sup> In summary, civil commitment hearings are the “disfavored stepchild in the large family of concerns that must be addressed by the justice system.”<sup>25</sup>

**II. CRITICAL RACE THEORY AND INVOLUNTARY COMMITMENT**

In the context of involuntary civil commitment, critical race theory (“CRT”) can be used as “a framework to theorize and understand the racial logics that are used to maintain the existence of an unethical and ineffective

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<sup>20</sup> Perlin, *supra* note 4, at 940-941.

<sup>21</sup> *Id.* at 941.

<sup>22</sup> *Id.*

<sup>23</sup> *Id.* at 942.

<sup>24</sup> *Id.* at 943.

<sup>25</sup> *Id.* at 945.

health law such as involuntary commitment”.<sup>26</sup> Specifically, how “ethnoracial statistics have historically been used to justify or even uphold the use of involuntary commitment.”<sup>27</sup> The “racialization of involuntary commitment is a feature not an error of the law.”<sup>28</sup> The subordination of Black people in the legal system is co-existent with that of people who have mental health issues. Perlin argues that this is reflective of individual judges’ explicit or implicit bias against people who fall outside the types of people that judges want to see in their community.<sup>29</sup>

While there is extensive research detailing the disproportionately large rate of imprisonment for African American men and other minorities, there is relatively little legal analysis on the use of mass involuntary civil commitment. However, involuntary commitment sites of confinement often mirror traditional prisons in regard to whom they target and confine, and the way in which they do it. In some cases, these sites are operated within correctional institutions even though the patients are not legally incarcerated.<sup>30</sup> Caspar describes this as an “impending catastrophe” where “confinement in a mental health institution can be more likely and more severe than the punishment a convict would receive for similar misconduct.”<sup>31</sup> Civil commitment may last longer than incarceration yet most states apply only a clear and convincing evidence standard as opposed to the criminal beyond a reasonable doubt standard.<sup>32</sup> This lower standard could be one explanation for the numerous cases where individuals have been committed based on a single misdiagnosis by a psychologist.<sup>33</sup>

The lower standard for a grant of civil commitment results in scenarios like the one presented by Wahbi & Beletsky where a Black man was killed six minutes and thirty seconds after an involuntary commitment order was issued.<sup>34</sup> Ronald Armstrong was a 43-year-old Black man who had been diagnosed with bipolar disorder and paranoid schizophrenia.<sup>35</sup> In April 2011, he allegedly stopped taking his medication for five days.<sup>36</sup> His sister convinced him to go to the hospital to be assessed because she believed that there was

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<sup>26</sup> *Id.*

<sup>27</sup> *Id.*

<sup>28</sup> *Id.*

<sup>29</sup> Perlin, *supra* note 4, at 942-943.

<sup>30</sup> Rafik Wahbi & Leo Beletsky, *Involuntary Commitment as “Carceral-Health Service”*: *From Healthcare-to-Prison Pipeline to a Public Health Abolition Praxis*, 50 *THE J. OF LAW, MED. & ETHICS* 23, 26 (2022).

<sup>31</sup> Caspar & Joukov, *supra* note 5, at 500-501.

<sup>32</sup> *Id.* at 501.

<sup>33</sup> *Id.*

<sup>34</sup> Wahbi & Beletsky, *supra* note 30, at 24.

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

evidence he had been self-harming.<sup>37</sup> According to the police report, during an initial evaluation he became nervous and frightened by the environment, so he left the hospital.<sup>38</sup> As a result, the examining physician determined that Armstrong was a danger to himself and began the involuntary commitment process; the police were also called.<sup>39</sup> When the police encountered Armstrong, the order had not yet been processed so they engaged him in conversation and tried to convince him to return to the hospital.<sup>40</sup> However, once they received word that the commitment order had been processed, they moved to detain Armstrong.<sup>41</sup>

The five officers present tried to remove Armstrong from a post he had wrapped himself around.<sup>42</sup> The police report noted that Armstrong was “anchored to the base of a stop signpost . . . in defiance of the [commitment] order” despite there being no evidence that Armstrong was capable of understanding that there was a commitment order issued and much less that he was defying it.<sup>43</sup> Just 30 seconds after the police were notified that the commitment order had been finalized, they deployed a taser on Armstrong five separate times.<sup>44</sup> Once they pulled him off the post, they pinned him down and handcuffed him.<sup>45</sup> While he was being pinned, he stated that he was choking and could not breathe.<sup>46</sup> The officers left him handcuffed on the ground and returned to their cars.<sup>47</sup> Armstrong’s sister noticed that he was unresponsive and not breathing.<sup>48</sup> Approximately six minutes and thirty seconds had passed between the civil commitment order being issued and police murdering Armstrong.<sup>49</sup>

Armstrong’s case primarily focused on whether use of the taser constituted excessive force, and there was no mention of the involuntary commitment order outside of a factual summary.<sup>50</sup> This was hardly an isolated incident as “law enforcement kill Black men with mental illness at significantly greater rates than white men.”<sup>51</sup> Even when individuals are not killed during

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37 *Id.*

38 *Id.*

39 *Id.*

40 *Id.*

41 *Id.*

42 *Id.*

43 *Id.*

44 *Id.*

45 *Id.*

46 *Id.*

47 *Id.*

48 *Id.*

49 *Id.*

50 *Estate of Armstrong v. Pinehurst*, 810 F.3d 892, 892 (4th Cir. 2016).

51 Wahbi & Beletsky, *supra* note 30, at 25.

apprehension, “violently restrained individuals are committed to so-called treatment centers for ‘rehabilitation’ but these sites are far from treatment or rehabilitation, but rather another form of prison or jail.”<sup>52</sup> This is more concerning because the use of involuntary commitment continues to increase even as rates of incarceration stabilize.<sup>53</sup>

### III. INSTITUTIONALIZATION AND INCARCERATION

#### A. Involuntary Commitment as a Carceral-Health Service

The argument that civil commitment is an extension of the racial carceral system begins by situating it within “the larger history of social, racial, and class control of the earliest penal systems.”<sup>54</sup> Michael Foucault references a “bad economy of power” where unilateral decisions are made with “regards to criminal doctrine, procedure, and punishment, etc.”<sup>55</sup> The goals of most penal reform throughout history have been a dispersion of the bad economy of power as opposed to an elimination or transformation.<sup>56</sup> As a result, reform never seeks to provide more humane treatment but rather “render [the power to punish] more regular, more effective, more constant, and more detailed in its effects; in short . . . increase its effects while diminishing its economic cost and its political cost . . . the new juridical theory of penalty corresponds . . . to a new ‘political economy’ of the power to punish.”<sup>57</sup>

Thus civil commitment is not just a health law with the “power to ‘treat’ individuals with serious mental health issues” but rather an extension of Ben-Moshe’s conception of the political economy of punishment.<sup>58</sup> This rests within a larger theory from Ben-Moshe that “the project of social control by the state, through the penal system, was connected to the targeted control and elimination of those with disabilities, including psychiatric, developmental, and physical.”<sup>59</sup> Wahbi & Beletsky argue that “involuntary commitment is not treatment for the sake of public safety, but rather . . . punish[ment] through violence . . . [specifically] violence on people and bodies that are deemed deviant.”<sup>60</sup> This expansion of the carceral state is described as having

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<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> Wahbi & Beletsky, *supra* note 30, at 26.

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> Liat Ben-Moshe, *Disabling Incarceration: Connecting Disability to Divergent Confinements in the USA*, 39 *CRITICAL SOC.* 385, 385 (2011).

<sup>58</sup> Wahbi & Beletsky, *supra* note 30, at 26.

<sup>59</sup> *Id.*

<sup>60</sup> *Id.* at 27.

three characteristics:

(1) that carceral expansion is not related to crime rates, (2) that the investment in punishment is directly related to divestment in other aspects of society that create equitable opportunity, and (3) that it is targeted toward the literal capture and metaphorical containment of black and other people of color, Indigenous peoples, transgender and gender-non-conforming people, young people from poor communities, people with mental health issues, and other groups who are disadvantaged by institutionalized oppression, and as such, it is an artifact of social control and exclusion.<sup>61</sup>

This theory of capture and control is not limited to prisons and institutions but rather carceral-type services that “replicate the control, surveillance, and punishment of the Prison Nation . . . thus, punitive and social services can become indistinguishable.”<sup>62</sup>

### **1. Abolishing Carceral-Health Services**

Prison industrial complex abolition is “more than just eliminating laws such as involuntary commitment, or getting rid of armed officers that respond to mental health crises.”<sup>63</sup> Rather, it is “preventing further harm and violence from happening, and when it does occur, to not respond with more violence.”<sup>64</sup> This “positive project” of abolition involves supporting existing systems of care and creating new ones that are more effective.<sup>65</sup> A possible solution to civil commitment as a carceral-health service is an integrated evidence-based health and social service model in tandem with non-carceral community-based emergency and crisis response teams.<sup>66</sup> The use of alternative approaches serves to “address the issues, instead of caging them away.”<sup>67</sup> These approaches can be expanded to include “alternate crisis response systems (988 number), funding harm reduction services, supervised consumption sites, expanding access to medication for addiction treatment, and much more.”<sup>68</sup>

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61 Beth E. Richie & Kayla M. Martensen, *Resisting Carcerality, Embracing Abolition: Implications for Feminist Social Work Practice*, 35 *AFFILIA* 12, 12 (2019).

62 Wahbi & Beletsky, *supra* note 30, at 27.

63 *Id.* at 28.

64 *Id.*

65 *Id.*; for a discussion on effectiveness, *see infra* Part IV.A.2.

66 Wahbi & Beletsky, *supra* note 30, at 28.

67 *Id.*

68 *Id.*



## **2. Prisoners with Disabilities at the Intersection**

An analysis of imprisonment from the lens of disability studies begins with looking at “the social and economic conditions of disablement and incarceration rather than looking at disability as a cause for criminal acts.”<sup>69</sup> Thus, disability within a carceral abolition framework is not “a natural biological entity, but related to economic and social conditions that lead to an increased chance of both disablement and imprisonment.”<sup>70</sup> Not to mention the cyclical nature of incarceration or civil commitment where “conditions of confinement may cause further mental deterioration in prisoners . . . [and] this further distresses those incarcerated and worsens their mental and physical health overall.”<sup>71</sup>

### **B. Political Economy and the Institution-Prison-Industrial Complex**

Political economy is another “explanatory scheme for the growing usage of confinement in capitalist societies.”<sup>72</sup> This involves a shift from “our understanding of disability oppression from discussions of stigma and deviance to that of systematic economic exclusion of people with disabilities.”<sup>73</sup> In brief, a neo-Marxist<sup>74</sup> analysis provides that “disability is an ideology upon which the capitalist system rests because it can regulate and control the unequal distribution of surplus by invoking biological difference as the ‘natural’ cause of inequality.”<sup>75</sup> This does not mean that the capitalist system regards people with disabilities as unproductive, rather “disability supports a whole industry of professionals that keeps the economy afloat, such as service providers, case managers, medical professionals, health care specialists, etc.”<sup>76</sup> Thus, disability is now used to describe a population which must be “surveilled for political-economic reasons.”<sup>77</sup> From the point of view of the institution-industrial complex, “disabled people are worth more to the gross domestic product when occupying institutional ‘beds’ than they are in their own homes.”<sup>78</sup> This helps to explain some of the underlying motivation for

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69 Ben-Moshe, *supra* note 57, at 397.

70 *Id.*

71 *Id.*

72 *Id.* at 390.

73 *Id.*

74 In this context, neo-Marxist relates to economic surpluses which are absorbed by imperialistic and militaristic government tendencies.

75 *Id.* at 391.

76 *Id.*

77 *Id.* at 392.

78 *Id.* at 393.

carceral civil commitment.

#### IV. THE ETHICS OF CIVIL COMMITMENT AND CIVIL COMMITMENT ALTERNATIVES

Joseph M. Livermore describes involuntary confinement as “the most serious deprivation of individual liberty that a society may impose.”<sup>79</sup> He goes on to identify that the “philosophical justifications for such a deprivation by means of the criminal process have been thoroughly explored. No such intellectual effort has been directed at providing justifications for societal use of civil commitment procedures.”<sup>80</sup> This lack of effort is exacerbated by what Susan Hawthorne and Amy Ihlán describe as a “social and medical context in which care for serious mental illnesses is at best inconsistent.”<sup>81</sup> The authors outline that because of the uniquely deficient role the courts have played in addressing mental illness, the “ethics of civil commitment for involuntary treatment . . . needs to go beyond the traditional focus on individual freedom and the harms of government coercion.”<sup>82</sup> Their article recognizes that the “public debate over involuntary treatment or confinement for mental illness reflects important shared assumptions of US constitutional law and popular political culture, where protection of individual freedom and the limitation of state power are primary concerns.”<sup>83</sup> As a result, they suggest “an alternative way of thinking about the purposes and practices of civil commitment under an ethics of care, where the conceptual focus shifts from individual autonomy to a recognition of social interdependence and the moral value of caring relationships”.<sup>84</sup>

There are three primary issues in tension when considering civil commitment: (1) how to maintain respect for individual liberty and autonomy; (2) concern for public safety; and (3) providing appropriate and effective treatment for mentally ill patients whose capacity to make their own treatment choices is contested.<sup>85</sup> There are also three “general social purposes”: (1) protecting the public from dangerous persons; (2) providing treatment for mental illness; and (3) providing for the basic physical needs of those unable to care for themselves.<sup>86</sup> The coalescence of these issues and purposes can be

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79 Joseph M. Livermore et al., *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 75 (1968).

80 *Id.*

81 Susan Hawthorne & Amy Ihlán, *Rethinking Civil Commitment: The Radical Resources of the Ethics of Care*, 1 PUB. PHIL. J. 1, 1 (2018).

82 *Id.*

83 *Id.*

84 *Id.* at 2.

85 *Id.*

86 *Id.*

seen in *O'Connor v. Donaldson* where the US Supreme Court held that “a State cannot constitutionally confine . . . a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”<sup>87</sup> However, when considering the ethics of civil commitment, this decision should represent the start of the discussion rather than the end. Because civil commitment takes place within the context of an adversarial legal system, there is a concern that the “needs for care and treatment of persons who have mental illness may often get lost in polarized ideological battles over the appropriate power of government and the provision of public resources to support mental health.”<sup>88</sup>

## A. The Ethics of Care

### 1. Relational Autonomy & Dignity

An ethics of care contends (or perhaps recognizes) that individuals are not solely and independently autonomous but rather, reliant on each other in “profound and ethically significant ways.”<sup>89</sup> This is related to a feminist recognition of both individual and community interdependence.<sup>90</sup> This interdependency necessarily extends beyond physical existence to “our ways of thinking and communicating, our received values, and aspects of our personhood established through social reciprocities.”<sup>91</sup> By expanding an ethic of care beyond familial relationships, difficulties arise with regard to justice, freedom, and autonomy.<sup>92</sup> Under an ethics of care, the government is responsible for individual welfare, but this is accompanied by a tension between “the partiality of individualized caring and the impartiality (arguably) required for justice and fairness.”<sup>93</sup> This tension introduces difficulty into the context of civil commitment as it may be “ethically justified for a caring, attached family to ‘win’ a civil commitment case and quite another matter for an uncaring, manipulative family to do so.”<sup>94</sup>

An ethics of care approach also introduces confrontation with the overarching narrative of US law and political culture that state intervention

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87 *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975).

88 Hawthorne, *supra* note 81, at 4.

89 *Id.* at 5.

90 *Id.*

91 *Id.* at 6. Contrast this with a European view of autonomy which emphasizes “solidarity, dignity, integrity, and vulnerability” as opposed to those views advanced in most US legal and political contexts.

92 *Id.*

93 *Id.*

94 *Id.*

in an individual's choices or actions infringes on liberty and autonomy.<sup>95</sup> In contrast, a relational view of autonomy only allows state intervention when it is beneficent from the perspective of the involved persons. This cooperative model which honors "the various relationships between the people who have mental illness, their families, friends, and caregivers, as well as mental health systems, government agencies, and the courts" will be further developed later in Section B.<sup>96</sup> The ultimate goal of this model is for "mentally ill persons to participate or collaborate in their care and treatment in a way that respects their contextualized capacities for agency."<sup>97</sup> This contextualized approach applies a sliding scale for competence in contrast with the "current adversarial commitment process under which individuals are considered either completely self-determining or effectively reduced to wards of the state."<sup>98</sup>

This approach should not be construed to mean that individuals lacking the ability to exercise mental and physical independence are not deserving of autonomy. In contrast, the current civil commitment system says that those with serious mental illness lack autonomy and thus it is permitted or even *encouraged* to override their expressed wishes. This system results in a complication where actions "understood as caring by the courts could be disempowering paternalism in disguise."<sup>99</sup> A Kantian perspective would hold that "the dignity people intrinsically possess provides sufficient reason for treating people well" but is generally applied in a way that ties dignity to rationality rather than agency.<sup>100</sup> This conception of dignity further "recapitulates the disempowerment of those whose rationality is impaired or impugned".<sup>101</sup> One response is that there is a directive to care for others not as a consequence of dignity but rather resulting from the care we ourselves need; rather than rationality, the source of dignity has been argued to be "the ability of a being to . . . receive care."<sup>102</sup> An individual's dignity can be protected from paternalism through "maximizing their involvement in defining their own needs and making their own care decisions."<sup>103</sup>

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95 *Id.*

96 *See infra* Part IV.B.

97 Hawthorne, *supra* note 81, at 7.

98 *Id.*

99 *Id.* at 8.

100 *Id.* Contrast this with a Catholic perspective that dignity is not based on rationality but is an innate characteristic of those with the *potentiality* of rationality.

101 *Id.*

102 Interview with Eva F. Kittay, *Critical Ethics of Care* (Jun. 16, 2013).

103 Hawthorne, *supra* note 81, at 9.

## 2. Effective Care

An ethics of care requires that the care being provided actually be effective in meeting the needs of the person receiving care.<sup>104</sup> This legitimizes civil commitment only when the program to which a person is committed is effective.<sup>105</sup> As outlined in Part I, Section A it is difficult to determine effectiveness when data analysis is almost non-existent.<sup>106</sup> And even if the data were available, there are a number of issues related to effectiveness: the meaning of “effective” varies by context, the “effectiveness” standard is difficult to meet for the treatment of many mental illnesses, and there is a need for ethical assessment of practical limits on providing effective care when it is unavailable.<sup>107</sup> Briefly returning to a dignity analysis, “effectiveness” needs to be determined relative to goals and needs in ways that express the wishes of the cared-for individual as closely as possible.<sup>108</sup> When those other than the individual being committed set the terms, it increases the risk of paternalistic or coercive treatment.<sup>109</sup> By clearly identifying “need for treatment” standards, there is a better chance of intervention “before the crisis of imminent dangerousness to self or others” and this may be accompanied by an existence for the individual that is “higher than ‘survival in freedom.’”<sup>110</sup>

Additionally, an ethics of care provides a counter to libertarian reasoning which allows citizens the “freedom to neglect those who have a mental illness.”<sup>111</sup> This allows for a shift in the “ethical and legal thinking about civil commitment for involuntary treatment of serious mental illness”.<sup>112</sup> If civil commitment proceedings are able (or can be made) to recognize a relational understanding of autonomy, they can better support the committed individual even if this support involves restrictions on individual liberty; but this necessitates respect of the individual’s dignity. The ethics of care is not merely the provision of care but rather the provision of *effective* care which emphasizes that “the care needed by people who have mental illnesses cannot be the responsibility of just a few . . . [but rather] the responsibility accrues to wider society to provide adequate funding and systems so that people who have mental illness are not neglected.”<sup>113</sup>

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104 *Id.*

105 *Id.*

106 *See supra* Part I.A.

107 Hawthorne, *supra* note 81, at 9.

108 *Id.*

109 *Id.*

110 *Id.* at 10.

111 *Id.*

112 *Id.* at 12.

113 *Id.*

## **B. Mental Health Courts as an Alternative to Involuntary Commitment**

One possible solution is the use of mental health courts (MHC). Although there is no single prototype, virtually all MHCs include a special docket handled by a particular judge, with the primary goal of diverting defendants from the criminal legal system and into treatment.<sup>114</sup> Because MHCs can divert persons with mental disabilities out of the criminal legal or involuntary commitment system, they provide an alternative to confinement. The MHC judge may function as “part of a mental health team that assesses the individual’s treatment needs”; then “the team formulates a treatment plan, and a court-employed case manager and court monitor track the individual’s participation in the treatment program and submit periodic reports to the judge concerning his or her progress.”<sup>115</sup> One judge describes an MHC as requiring: (1) a therapeutic environment and dedicated team; (2) an environment free from stigmatizing labels; (3) opportunities for deferred sentences and diversion away from the criminal system; (4) the least restrictive alternatives; (5) decision-making that is interdependent; (6) coordinated treatment, and (7) a review process that is meaningful.<sup>116</sup> The ultimate goal of MHCs is to divert persons with mental disabilities out of the criminal legal system.<sup>117</sup> This is accompanied by proceedings in which “defendants participate more actively and directly than in typical criminal courts, often speaking directly with the judge instead of sitting silently while their defense attorney speaks for them.”<sup>118</sup>

### **1. Procedural Justice**

Procedural justice is the theory that “people’s evaluations of the resolution of a dispute are influenced more by their perception of the fairness of the process employed than by their belief regarding whether the ‘right’ outcome was reached.”<sup>119</sup> Perlin argues that “individuals with mental disabilities, like all other citizens, are affected by such process values as participation, dignity, and trust, and that experiencing arbitrariness in procedure leads to social malaise and decreases people’s willingness to be integrated into

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114 Perlin, *supra* note 4, at 947.

115 *Id.* at 947-948.

116 *Id.* at 949.

117 *Id.* at 950.

118 *Id.* at 951.

119 *Id.* at 954.

the polity, accepting its authorities and following its rules.”<sup>120</sup> The traditional civil court does not give patients the same opportunities for procedural justice afforded by MHCs.<sup>121</sup>

## 2. Therapeutic Jurisprudence

Therapeutic jurisprudence is a “model for assessing the impact of case law and legislation, recognizing that, as a therapeutic agent, the law can have therapeutic or anti-therapeutic consequences.”<sup>122</sup> The ultimate goal of this model is to “determine whether legal rules, procedures, and lawyer roles can or should be reshaped to enhance their therapeutic potential while not subordinating due process principles.”<sup>123</sup> The context of this model involves: (1) the extent to which legal rules, procedures, and lawyer roles can or should be reshaped to enhance their therapeutic potential while not subordinating due process principles; (2) how the law actually impacts people’s lives; (3) whether the court system supports an ethic of care;<sup>124</sup> and (4) the extent to which the legal system abides by voice, validation, and voluntariness.<sup>125</sup> This perception of a fair hearing is therapeutic because “it contributes to the individual’s sense of dignity and conveys that he or she is being taken seriously.”<sup>126</sup>

## CONCLUSION

Civil commitment is one example of how health, medicine, and the law intersect to perpetuate the Institution-Prison-Industrial complex. Engaging in civil commitment abolition is made especially difficult by the lack of accessible data around the issue. Still, even without this information, “enough is known for action”<sup>127</sup> and both the legal and medical communities have an obligation to prevent civil commitment from continuing to be used as a form of mass incarceration. The disestablishment of white supremacy is not possible without abolition of the healthcare-to-prison pipeline.

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120 *Id.* at 955.

121 *Id.* at 957.

122 *Id.*

123 *Id.*

124 *See supra* Part IV.A.

125 Perlin, *supra* note 4, at 957-958.

126 *Id.* at 926; for a discussion on dignity, *see supra* Part IV.A.1.

127 Andrew Hahn et al., *Dropouts in America: Enough Is Known for Action. A Report for Policymakers and Grantmakers*, The Institute for Educational Leadership (1987).