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THE UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

FROM BEDLAM TO THERAPEUTIC JURISPRUDENCE: ARE JUDGES ADEQUATELY PREPARED TO MAKE CIVIL COMMITMENT DECISIONS?

A Dissertation

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

degree of

Doctor of Philosophy

By

Gail A. Poyner
Norman, Oklahoma
2001

UMI Number: 3009541

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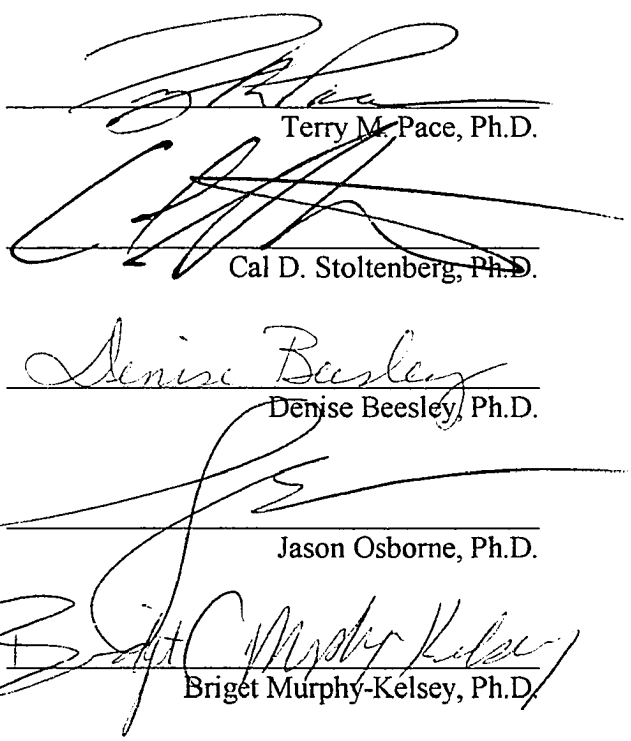
BY



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ACKNOWLEDGEMENTS

Social Scientist Kurt Lewin once noted that, "I have always found myself unable to think as a single person." (Corey, 1995), and such is the case with me. Indeed, two groups of individuals have influenced me greatly, have supported me tirelessly, and have changed, in many ways, how I view the world. Hence, my sincere expression of gratitude to the following individuals for sharing their knowledge and expertise, and allowing me to think more collectively: First, my advisors and instructors: Dr. Jody Newman for sharing her intelligence and insight thereby expanding my thinking and influencing my personal growth; Dr. Karen Scheel for her intelligence, wisdom and inspiration, for increasing my aspirations and confidence, and for being an excellent mentor and laudable role model; and Dr. Terry Pace, whose intellect and superior clinical skills I can only hope to some day emulate.

I also express my gratitude for several excellent instructors, committee members, role models and strong supporters of my educational endeavors: Dr. Cal Stoltenberg, Dr. Avriham Scherman, Dr. Denise Beesley. Dr. Jason Osborne, Dr. Briget Murphy-Kelsey and Dr. Loretto Prieto. Each has contributed in countless ways to my education, personal and professional development, and especially to my ability to bring this dissertation to its final defense.

Next, I express my profound gratitude and appreciation to my family. Trite as it may sound, I truly could not have accomplished what I have without their support, constant

encouragement, and sacrifice. Indeed, my accomplishments are also that of my family. Don and Beverly Davis, you are wonderful parents. Your examples of goodness have, and continue to inspire me. Kimberly, Jeffrey, Amy, Joseph, Lesley and Spencer—I acknowledge your willingness to be self-sufficient, understanding, supportive and simply great kids while your mother followed her mid-life dreams. Each of you adds immeasurable light to my life. And Gene, my husband, very best friend and greatest supporter, you deserve the height of my gratitude for your progressive and giving view of what it means to be a true life's partner, and for how you have demonstrated your love and support thorough personal sacrifice. You are undeniably the best, and this dissertation is dedicated to you.

Lastly, and ultimately most importantly, I thank my Father in Heaven for blessing me with a mind that has the capacity to learn and grow. "The glory of God is intelligence...." (Doctrine & Covenants 93:36). Any intelligence I may have comes from Providence, and any glory attendant to it clearly goes to the same.

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ABSTRACT

Historically, mentally ill individuals have been subject to inhumane treatment. However, the late 1700's and early 1800's saw major changes in the manner in which the mentally infirm were both housed and treated. Beginning in Europe and then spreading to the United States, reforms designed to improve those conditions were implemented. Later reformations targeted the rights of the mentally ill, and laws were subsequently drafted and passed to protect the same. Currently, mentally ill individuals who face involuntary commitment for treatment have clear, judicially defined rights. No longer can they be involuntarily committed to treatment without legal and procedural safeguards. The judges who make involuntary commitment decisions are mandated to follow certain criteria during commitment hearings. The current study investigated the training practices of American Bar Association (ABA) and American Association of Law Schools (AALS) accredited law schools with regard to abnormal psychology and mental health law. The purpose of the study was to determine the extent to which mental health judges are educationally prepared to apply mental health law as it applies to the abnormal psychology/involuntary commitment of those appearing on their dockets. Because foundational knowledge in abnormal psychology and extant mental health law is essential to making appropriate involuntary commitment decisions, the Deans of Academic Affairs at all ABA and AALS accredited law schools in the United States and U.S. Territories were surveyed. Of the 185 accredited schools, 109 responses were received for a total response rate of 59%. The results indicate that 41% of the programs offer no coursework

in the areas of mental health law and abnormal psychology, with 59% offering coursework ranging from 1-6 courses. Further, results indicate that 37% of the responding Deans rated training in mental health law as extremely *unimportant* to somewhat *unimportant*, and 65% of deans rated training in abnormal psychology the same. The results of the study were integrated with the extant literature on therapeutic jurisprudence—how the perception of one's involuntary commitment hearing affects treatment outcome—in order to develop possible training recommendations for APA and AALS accredited law programs to consider.

CHAPTER I

INTRODUCTION

No one can dispute that treatment of the mentally ill has dramatically changed, indeed improved, due to humanitarian reform and the application of legal statutes designed to protect the rights of those afflicted with mental impairment. Centuries old accounts of the hideous conditions under which the mentally ill lived and were "treated," stand in stark contrast to the current care of those so afflicted. No longer can family members, police officers, physicians, or judges arbitrarily commit an individual to psychiatric treatment without due process and the protections afforded by current mental health law.

The purpose of this paper is not to advocate for reform or for the legislation of additional laws to protect those whose mental functions are compromised. The objectives of this study are to examine the standard training practices of American Bar Association (ABA) and American Association of Law Schools (AALS) accredited training programs with regard to mental health law and abnormal psychology. The questions addressed in this study include: Are judges adequately prepared (educationally) to appropriately apply mental health law in involuntary commitment hearings? What percentage of ABA and AALS accredited training programs require training in mental health law and abnormal psychology? How much training is required of future judges in these areas? What methods are used to train judges in recognizing mental illness and applying the appropriate mental health statute? What recommendations emerge for strengthening

judicial preparation in the areas of mental health law and abnormal psychology? Before those questions can be addressed, the historical significance of the treatment of the mentally ill should be revisited.

CHAPTER II

REVIEW OF THE LITERATURE

From Where We've Come

Historically, mentally impaired individuals have been subject to inhumane legal and "therapeutic" practices. In the 1400's, one could be indefinitely committed to a mental institution with no legal or procedural safeguards. Hilgard (1987) offers a concise look at an era whose appalling treatment of those thought to be mentally ill reminds us of how far we've come. From 1402 until 1930, the Bethlehem Royal Hospital in England was the standard of institutionalization, with similar conditions existing throughout most of Europe. Bedlam (Bethlehem Royal's nickname) came to be the metaphor for anything confusing or resembling chaos due to the conditions that existed at the hospital. Referred to as inmates, the mentally ill were forced to endure the degrading existence of filth, beatings, being chained to one's bed (often in one's own excrement), and eating food better fit for animals. They were housed in dark, poorly ventilated, and often, unheated buildings. "Treatment," if there was any, often consisted of purging or bloodletting, or of subjecting patients to spinning cages or other odd contraptions designed to "cure" the afflicted of their mental illness (Hilgard, 1987).

Hilgard (1987), Szasz (1974) and Benjamin (1997), among others, attribute a move to more humane treatment of the mentally ill to Frenchman, Philippe Pinel. A physician appointed by the leaders of the French Revolution to provide medical oversight at the

beheadings of the revolution's enemies, Pinel detested such violence and asked for reassignment to hospitals for the mad and insane. Assigned in 1793 to head the asylum of Bicetre (a hospital for men), Pinel made major changes by treating the mentally ill under his care with kindness and compassion, by unchaining them, properly feeding them, and halting physical beatings. As quoted in Benjamin (1997), Pinel (1806) mandated that "No man was allowed to strike a maniac even in his own defense. No concessions however humble, nor complaints nor threats were allowed to interfere with the observance of this law. The guilty was instantly dismissed from the service." (pg 90).

Pinel ultimately extended his work to the Salpetriere, Bicetre's female counterpart, and encouraged the idea of viewing the mentally incapacitated as deserving humane treatment, and not the oppressive disdain to which they were currently subjected. Reports kept during that era indicated that Pinel's work contributed to at least one very positive outcome. Hothersall (1995), as cited in Benjamin (1997), noted that of the 261 mentally ill individuals admitted to the Bictre in the two years prior to Pinel's arrival, 58% of them died within a year of their admission. During the first two year's of Pinel's reforms, however, the mortality rate was a much reduced 12%.

In his chronicle of the treatment of those lacking mental health, Hilard (1987) writes of others who, independent of Philippe Pinel, forwarded the movement of offering civilized care for those whose minds had betrayed them. One such person was a Quaker by the name of William Tuke. A tea merchant by trade, Tuke heard about the incarceration, beating, and subsequent death of a mental patient, and began visiting the insane asylums in his locale. The wretched conditions of those asylums convinced him to open the York Retreat, a country home, in 1796. The prison-like atmosphere of the

asylums was notably absent from Tuke's retreat, as were the standard medical treatments of purging and bloodletting. The retreat represented an incredible improvement over former conditions.

According to Hilgard (1987), the movement soon spread to the United States and was advanced, in part, by Eli Todd who was a practicing physician and who addressed the Connecticut Medical Society about the work of Pinel. In 1824, the Hartford Retreat was established, with Eli Todd as its medical director. Based on his example, several states soon followed suit and founded publicly supported hospitals for the mentally infirm. Unfortunately, though, many of those were only marginally better than the asylums that had preceded them, and many of the mentally ill continued to be housed in jails or other facilities for the needy. It was Dorothea Dix, a Sunday School teacher in Boston, who took notice of the maltreatment of mentally ill patients who were routinely housed with criminals. Over a 40-year period, she succeeded in improving the facilities in several states, building or renovating 30 other state institutions, and influencing the same progress in Europe and Japan.

Each of these reforms, observes Hilgard (1987), contributed to asylums becoming hospitals whose patients had the opportunity to recover and regain their freedom. Many of the patients remained ill but, due to the reforms, they were no longer forced to reside with criminals. And even though the mentally ill continued to be regularly restrained, and no medical modalities existed to treat them, the early 19th century saw the beginnings of humane conditions for some of its neediest individuals. But even with improved living conditions, actual treatment was relatively nonexistent at the time. It was Johann Reil, a German physician, who in 1803 first introduced the notion that mental illness was a

psychological phenomenon and should be treated with psychological methods. He advocated that the term "hospital for psychotherapy," replace "lunatic asylum" when referring to those places designated to treat the mentally ill. He promoted a hospital where the incurable would be made comfortable, be given things to occupy their time, and the treatable to receive therapy with the hope of curing their mental illness.

Hilgard (1987) and Benjamin (1997) cite others as having early, yet profound effects on the course of reforming the process whereby the mentally ill received help for their various afflictions. Charcot, Janet, and Freud, among others, further advanced psychotherapy as a treatment for mental illness, which clearly offered vast improvements on earlier methods. Another influential person was Clifford Beers, who was himself a former mentally ill patient, and who, in 1908, wrote *The Mind That Found Itself.* The "Mental Hygiene Movement" was initiated as a result of Beers' personal and forthcoming book. Beers' own words offer a sad commentary on the need for reform. Indeed, had it not been for his will to survive, as well as his articulate accounting of the same, his first-hand account of his treatment in an insane asylum of the time (and his subsequent movement) might have never come to fruition. Beers' book reveals that he was placed in an insane asylum to be treated for "....a mental civil war, which I fought single-handed on a battlefield within the compass of my skull." (pg 1). Indeed, Beers chronicles his stay in the asylum, which began with "....fifteen interminable hours...." (pg 133) in a strait jacket. In sobering detail he shares with the reader an account of a particularly cruel, and apparently commonplace, attack while in the asylum:

> On the night of November 25th, 1902, the head attendant and one of his assistants passed my door. They were returning from one of the dances, which at intervals during the winter, the management provides for the nurses and attendants. While they were within hearing, I asked for a drink of water. It was a carefully worded

request. But they were in a hurry to get to bed, and refused me with curses. Then I replied in kind.

"If I come there I'll kill you," one of them said. "Well, you won't get in if I can help it," I replied, as I braced my iron bedstead against the door.

My defiance and defences (sic) gave the attendants the excuse for which they had said they were waiting; and my success in keeping them out for two or three minutes only served to enrage them. By the time they had gained entrance they had become furies. One was a young man of twenty-seven. Physically he was a fine specimen of manhood; morally he was deficient—thanks to the dehumanizing effect of several years in the employ of different institutions whose officials countenanced improper methods of care and treatment. It was he who now attacked me in the dark of my prison room. The head attendant stood by, holding a lantern which shed a dim light.

The door once open, I offered no further resistance. First I was knocked down. Then for several minutes I was kicked about the room—struck, kneed and choked. My assailant even attempted to grind his heel into my cheek. In this he failed, for I was there protected by a heavy beard which I wore at that time. But my shins, elbows, and back were cut by his heavy shoes; and had I not instinctively drawn up my knees to my elbows for the protection of my body, I might have been seriously, perhaps fatally, injured. As it was, I was severely cut and bruised. When my strength was nearly gone, I feigned unconsciousness. This ruse alone saved me from further punishment, for usually a premeditated assault is not ended until the patient is mute and helpless. When they had accomplished their purpose, they left me huddled in a corner to wear out the night as best I might—to live or die for all they cared.

The next morning, when the assistant physician appeared, he was accompanied as usual by the guilty head attendant who, on the previous night, had held the lantern. "Doctor," I said, "I have something to tell you,"—and I glanced significantly at the attendant. "Last night I had a most unusual experience. I have had many imaginary experiences during the past two years and a half, and it may be that last night's was not real. Perhaps the whole thing was phantasmagoric—like what I used to see during the first months of my illness. Whether it was so or not I shall leave you to judge. It just happens to be my impression that I was brutally assaulted last night. If it was a dream, it is the first thing of the kind that ever left visible evidence on my body."

With that I uncovered to the doctor a score of bruises and lacerations. I knew these would be more impressive than any words of mine. The doctor put on a knowing look, but said nothing and soon left the room. His guilty subordinate tried to appear unconcerned, and I really believe he thought me not absolutely sure of the events of the previous night, or at least unaware of his share in them (Beers, 1908, pgs 160-163).

Beers' movement, "I have decided to devote the next few years of my life to correcting abuses now in existence in every asylum in this country..." (pg.199) focused on the problems of the mentally ill, as well as increased the awareness of those inclined to acknowledge a heretofore relatively ignored and disenfranchised population.

But change was slow. Even in the 1960's, the president of the American Psychiatric Association referred to America's state hospitals as "bankrupt beyond remedy" (Perlin, 2000). Social activists of the day were still highly critical of the treatment the mentally ill received at the hands of government-funded institutions. Perlin (2000), in his book *The Hidden Prejudice, Mental Disability on Trial*, quotes Albert Deutsch, who testified before Congress about his investigations of the state hospitals of the day (1961):

> Some physicians I interviewed frankly admitted that the animals of nearby piggeries were better housed, fed and treated than many of the patients on their wards. I saw hundreds of sick people shackled, strapped, straitjacketed, and bound to their beds. I saw mental patients forced to eat meals with their hands because there were not enough spoons and other tableware to go around—not because they couldn't be trusted to eat like humans.....I found evidence of physical brutality, but that paled into insignificance when compared with the excruciating suffering stemming from prolonged, enforced, idleness, herdlike crowding, lack of privacy, depersonalization, and the overall atmosphere of neglect. The fault lay...with the general community that not only tolerated but enforced these subhuman conditions through financial penury, ignorance, fear and indifference. (pg 114).

Other social activists became involved in the move for better treatment of the mentally ill, and the 1960's and 1970's were rife with debates about the same. Soon, the debates gravitated to the legal domain and lawsuits and constitutional inquiries followed in an attempt to offer the mentally ill full protection under the law (Perlin, 2000).

Indeed, the process of reformation had begun, and the early 19th century began the process of significant improvement, as compared to its 18th century predecessor, with regard to how the mentally ill were viewed, housed, and treated. Conditions remained far

from ideal, but were in stark contrast to earlier times. But however improved conditions were, the fact remained that coerced entrance into the world of institutionalization was relatively uncomplicated, and could still be accomplished against one's will, and without legal, medical, or procedural safeguards.

A Brief History of Civil Commitment

With the development of state and public hospitals wherein the mentally impaired could receive help for their various conditions, concomitant attention was given to the process of civilly committing one to such treatment. Prior to the mid 19th century, family members, police, physicians or others could easily commit the mentally infirm to involuntary treatment, solely on the basis that the person was "in need of treatment." It was generally assumed that family members, and others, were acting in the patient's best interests and so little judicial involvement was deemed necessary. However, when state facilities began to proliferate, it became necessary to look at some controls for the process of civil commitment, and so the much needed, albeit immature, process of legislative purview was initiated. It now became more difficult for others to civilly commit the heretofore-disenfranchised "lunatics" and "insane," as the mentally ill now had the beginnings of a legal voice. No longer could greedy relatives collude with physicians to institutionalize their wealthy, but disparaged, family members (as was often purported to be the case), nor could troublesome family members be civilly committed without a modicum of due process (Appelbaum 1994).

Much like Clifford Beers, another former patient, Mrs. E.P.W. Packard, sought change with regard to the involuntary commitment of the mentally ill. She advocated for jury trials for those faced with civil commitment so that the rationale for such action could be

formally adjudicated. The work of Mrs. Packard, combined with that of others, had the effect of requiring hearings for the mentally ill—including those at private hospitals. It also impacted the medical aspect of commitment by requiring physicians to actually examine potential candidates prior to proceedings for commitment, as well as sign an affidavit that noted that the physician did not stand to gain financially from such an action (Appelbaum 1994; Szasz 1963).

The public attention afforded the process of involuntarily detaining patients waxed and waned according to the political emphasis of the times. When those advocating rapid hospitalization brought their message to the fore, the push for judicial reform and addition of stringent controls was reduced. However, when a more civil libertarian approach was promoted, protective, legal statutes took the spotlight, and the push for change intensified. Indeed, the first half of the twentieth century saw an abundance of the former, as more and more concern was expressed over patients having to endure legal hearings more reminiscent of criminal proceedings than expeditious treatment for the mentally ill. Social activists proposed that the power of civil commitment be transferred away from the court and into the domain of medicine. Using a medico-legal model, one or two physicians would assume the authority to make such decisions, with a patient having an after-the-fact hearing only if he/she so desired. Some states adopted such statutes. Others elected to continue with mandatory judicial hearings, but left an as yet unmentioned, although significant, problem in the hands of judges. The problem, that of the judge deciding whether or not to inform civil commitment candidates about their hearings, was ever salient, and became the crux of future judicial decisions with regard to involuntary commitment (Appelbaum 1994).

The legislative reform of involuntary commitment laws has been, like most legal major decisions, more a process than an event. Various tenets have influenced that process and have been reflected through the years in numerous decisions made on state and Supreme Court levels. Applebaum (1997), in one of his many looks at the laws and process of civil commitment, sums up the reforms made from 1964-1979:

> These forces, taken as a whole, culminated in a radical transformation of the law of civil commitment that essentially altered the status quo in every state in the nation over the course of 15 years. Use of involuntary commitment was limited to persons who were likely to be dangerous to themselves or others, the latter category including those so impaired as to be unable to meet their basic needs. The law allowing hospitalization of persons solely because they were "in need of treatment"—the historic standard of commitment in this country—was abandoned. In addition, a set of procedural rights was imported from the criminal law, including rights to a hearing, notice, representation by an attorney, to testify on ones' own behalf, to call and cross-examine witnesses, and to exclude evidence that did not meet the ordinary standards of admissibility. Although states varied in the details of their statutes, the basic thrust of the reforms was similar in every state (pgs 136-137).

Citing the copious court cases that provided the foundation for today's civil commitment laws is beyond the scope of this paper. However, even the most concise history of emergency detention laws would not be complete without taking note of the Federal Court case of *Lessard v. Schmidt*. Although she couldn't have known it at the time, Alberta Lessard would significantly influence the course of laws surrounding civil commitment, and greatly alter procedural mandates as they applied to the mentally ill and due process. According to Appelbaum (1994) Ms. Lessard was taken into custody in the Fall of 1971 by two police officers, and subsequently escorted to a local mental health center near her home in Wisconsin. Little is recorded as to what prompted authorities to place Alberta under an order of "emergency detention for mental observation," but it is known that she voiced unusual ideas and that she may have been a danger to herself several weeks before her detention.

Three days after being taken into custody, County Court Judge Christ T. Seraphim presided over a hearing wherein the two police officers, who had removed Ms. Lessard from her home, reiterated their rationale for taking her into protective custody. They must have been persuasive in their allegations, because Judge Seraphim authorized the hospital, in which Lessard was being held, to keep her an additional ten days—even though Lessard herself was not present at the hearing, nor had she received any notification of it. What happened next would have a profound influence on civil commitment laws in the United States (Appelbaum 1994).

Several days after Lessard's first hearing, a psychiatrist from the hospital told the court that the patient was suffering from schizophrenia and recommended "permanent commitment." Again, without Lessard being present, or even having knowledge of the hearings, Judge Seraphim prolonged her detention during *two* subsequent court proceedings. At no time was Ms. Lessard given the opportunity to refute the claims being made about her mental health. Whether the court underestimated Lessard's mental acuity, or whether no thought was given to her feelings about the matter, is not known. What is known is that at Lessard's formal commitment hearing on November 24, 1971, Judge Seraphim ordered 30 more days of commitment based on the fact that she was "mentally ill." What is also known is that Lessard contacted Milwaukee Legal Services and obtained legal representation. Moreover, her attorney quickly filed suit in federal court on her behalf and on behalf of others in the state of Wisconsin who were similarly affected. The wheels of justice turned, albeit slowly, but Alberta Lessard had been heard. Indeed, at the impetus of one allegedly mentally ill woman, a new standard for involuntary commitment was born (Appelbaum 1994).

Nearly a year after Alberta Lessard was involuntarily removed from her home and committed to psychiatric treatment, the court handed down its opinion. Appelbaum (1994) outlines the opinion, as well as the impact it had on future laws.

> The court held that "the state must bear the burden of proving that there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others." This finding of dangerousness must be based on a recent overt act, attempt, or threat to inflict substantial harm. As if to emphasize the restrictive nature of this standard, the judges commented in a footnote, "Even an overt attempt to substantially harm oneself cannot be the basis for commitment unless the person is found to be 1) mentally ill and 2) in immediate danger at the time of the hearing of doing further harm to oneself." The court also addressed the question of the procedures that must attend the commitment process. It ruled that a preliminary hearing must be held within 48 hours of detention to determine whether probable cause existed to believe that the person was committable, with rights to notice, to attendance, and to representation by counsel. A full hearing was required within 10 to 14 days.
>
> *Lessard* dispensed with the historic standard for civil commitment and, in a stroke, substituted a vastly constricted dangerousness requirement. Simultaneously, it imported a rigorous set of procedures from the criminal law that went far beyond those imposed during any previous period of reform. By the end of the 1970's,.....every state either had changed its statute to restrict hospitalization to persons who were dangerous to themselves or others (including dangerousness by virtue of "grave disability," defined as an inability to met one's basic needs) or had interpreted its preexisting statute in this way so as to "save" it from being found unconstitutional. The triumph was complete for those who believed that the state's power to confine the mentally ill, although legitimate, represented a massive invasion of liberty that could only be permitted in the most limited circumstances (pgs 27-28).

Reactions to the dramatic changes in the rights afforded to those presumed mentally ill have varied. Embraced by some, and eschewed by others, subsequent civil commitment law has been examined, reexamined, commented on, challenged, and explored at length in the literature. One state in particular, New Jersey, decided to take a close look at the extent and limitations of their mental health law. That look culminated in a seven-year reform, which saw their mental health law repealed and amended. The reformed bill was passed by the assembly and is summed up in the State's Committee Statement, which

reflects their progressive intent (Senate Revenue, Finance and Appropriations Committee Statement Assembly, No. 1813—L. 1987, c. 116):

> This bill, as amended, revises the statutes concerning involuntary civil commitment to reflect clinical and programmatic advances and to incorporate language based on recent court decisions and rules. The bill provides that a person shall be involuntarily committed to a short-term care or psychiatric facility or a special psychiatric hospital only if mentally ill and dangerous to himself, others or to property, and be retained based upon clear and convincing evidence only. The bill requires treatment consistent with the person's clinical condition and a person shall be hospitalized only when clinically necessary. This bill also encourages the development of community-based mental health screening services and short-term care facilities (pg 256).

Mental health law and the issue of civil commitment, continues to be debated by legal and social scientists. Although beyond the scope of this study, the legal and societal ramifications of certain forms of involuntary commitment go beyond typical mental illnesses and extend into domains that cause heated debate. One such debate centers on the civil commitment of sexual offenders, often broadly described as having impulse control disorders. Most salient to the debate is whether sexual offenders *can* be effectively treated, and whether their particular mental illness requires commitment beyond the period of judicial incarceration until such time they can be deemed no longer a danger to others. Laws covering just this eventuality are now appearing on the books of several states, and add to the ever-changing and controversial landscape of civil commitment (Cornwell, 1998).

Indeed, the rise of mental health courts has been receiving a great deal of attention. The American Psychological Association Monitor (2001) reported that recent legislation to create a national demonstration program for mental health courts recently passed through the 106th Congress with bipartisan support. This legislation will allow for the Department of Justice to use up to $10 million annually to give grants to state and local

governments for programs to divert mentally ill or mentally retarded offenders into voluntary outpatient or inpatient treatment. Given that social scientists estimate that some 300,000 mentally ill individuals occupy our prisons and jails at any given time, such a program might have the power to both treat the mentally ill, and reduce the load on the criminal justice system (APA, 2001).

In an earlier, but related article, the American Psychological Monitor (2000) reported that 16% of all inmates and state prisons suffer from mental illness, and that from 24-40% of America's mentally ill will have contact with the criminal justice system. The article noted that too many mentally ill people are sent to jail or prison instead of receiving treatment. As a solution, some states are establishing the aforementioned mental health courts, where the mentally ill are ordered into treatment, instead of being incarcerated. The article recounts the case of "Mary," a woman with schizophrenia who had been accused of loitering. Under the old system, Mary would have had to wait, in jail, for 21 days for her case to be heard. Under the mental health court system, Mary was instead mandated into treatment for her schizophrenia as well as her substance abuse. In San Bernardino, California, according to the Monitor article, the demand for mental health court services has overwhelmed their capacity to provide them.

> San Bernardino began its mental health court, Supervised Treatment After Release (STAR) last January. As with others of its type, the court places mentally ill criminal offenders in an intensive mental health treatment program instead of jail. But it's also unique because it's one of the few to handle predominantly nonviolent felony cases, and it requires participants to live in board-and-care facilities where they receive counseling, medications and supervision.
>
> The country's public defender recommends defendants for the mental health court—most have been diagnosed with serious mental illness and are facing substantial jail time. The program was designed to last one year but participants may spend more or less time in the program, depending on their individual

> progress and how long it takes them to get back on their feet. They may also hold a job or go to school while in the program, depending on their abilities (pg 59).

The subject of civil commitment can elicit some very strident opinions from those familiar with the process of treating and protecting the rights of the mentally ill. Basically, two general positions emerge with regard to the mandated treatment of the mentally ill. Following is an overview of those contrasting views.

Civil Libertarians vs. "Dying With Rights On"

The process of formulating laws to protect the rights of the mentally ill has not been without debate. Disparate views have marked the judicial/mental health landscape, and have been alternately responsible for bringing discrete agendas to the fore and influencing the direction of the legislation at the time. The strata of opinion with regard to the rights of those who may be in need of mental health treatment is much more complex than the dichotomous presentation of civil libertarians vs. those who advocate for more protective positions of the right, or need, to treat those so afflicted. It is doubtful that anyone familiar with the tenets of the individual arguments would consider them totally and mutually exclusive. And yet two basic positions have emerged with regard to the rights afforded those who suffer from mental impairment. For the purposes of this paper, those positions have been titled Civil Libertarians, those advocating against what they consider legally sanctioned coercion, and "Dying With Rights On," a term made popular by a Wisconsin psychiatrist by the name of Darryl Treffert, an early critic of civil commitment law reform (Appelbaum, 1994). Although both sides of the debate have merit and could be explored at length, their full exploration is beyond the scope of this paper and so will be only overviewed here.

One of the more prolific, and controversial, writers of treatises addressing the rights of the mentally ill (a term he feels stigmatizes those so labeled) is physician Thomas S. Szasz. In his 1974 publication of *The Myth of Mental Illness*, he postulates that psychiatry is really a process of "moral, political, and social action." A strident protector of the rights of those whose behavior is often considered deviant, Szasz describes the psychiatrist "..... as social engineer or controller of social deviance. In this role, the psychiatrist acts as priest and policeman, arbitrator and judge, parent and warden: he coerces and manipulates, punishes and rewards, and otherwise influences and compels people, often by relying on the police power of the state....." Szasz leaves no doubt in the reader's mind as to his position with regard to the involuntary or civil commitment of the mentally ill when he writes: "I am opposed, on moral and political grounds, to all psychiatric interventions which are involuntary; and, on personal grounds, to all such interventions which curtail the client's autonomy" (Szasz, 1974).

Michael Perlin, a less controversial, yet equally prolific social scientist with regard to researching the rights of the mentally ill, has done much in the way of offering a well-researched and balanced view of this debate-provoking subject. Indeed, he has dedicated his career to investigating the rights of the mentally ill as well as their treatment (personal communication, 2000). In his latest book, *The Hidden Prejudice—Mental Disability on Trial* (Perlin, 2000), Perlin speaks to the sometimes capricious nature of civil commitment. He notes that involuntary commitment decisions may not always be centered on "clinically coherent grounds."

> Doctors recommend hospitalization 'whenever they are in doubt about a patient's potential for suicide since it is always better to err on the side of safety,' notwithstanding empirical research concluding that it is not possible to predict suicide, even among high-risk groups of inpatients. This type of decision making

> blocks access to any inquiry about whether the patient has social support in the community, a factor that is frequently associated with positive mental health outcomes. (pg 87)

With regard to the ethical actions of some who want to mandate treatment under any circumstance, Perlin (2000) writes further:

> There is a flip side to this arrogation of morality. Using the rankest form of passive aggressive behavior, some mental health professionals have advised families to put their mentally ill relatives out on the streets where they will either find life so difficult that they will accept treatment or will deteriorate to the point at which there will no longer be any question as to their eligibility for involuntary civil commitment. To suggest that this stands both medical ethics and the legal system on their heads belabors the obvious. (pg 87)

Perlin's research (2000) acknowledges that so great are the motivations of some to involuntarily commit, that they may "reshape" a patient's actual presentation by reporting a higher level of dangerousness in order to have them committed. Further, those individuals who "attempt to assert their constitutional and statutory rights" are often viewed as "trouble makers" (pg 89).

The debate over the moral, medical and legal legitimacy of involuntarily committing a person to treatment is not without vehemence, nor is it limited to an American forum. Mason & Jennings (1997), commenting on Britain's 1983 Mental Health Act, use such phrases as "professional hostage taking," and note that "Involuntary commitment..... can be viewed as analogous to imprisonment: patients lose their liberty and many of their civil rights and are forced to adhere to institutional regulations." Further, they state that "The use of the Mental Health Act.....can be seen as a weapon of social control exercised under the influence of medical jurisprudence."

Others have written about the right to refuse treatment. Indeed, legal scholar Bruce Winnick (1997) dedicated an entire volume to the subject when he wrote *The Right to*

Refuse Mental Health Treatment. In his book, Winnick describes the potential for abuse when involuntarily committing individuals to treatment. He says that involuntary treatment, despite its controversy, is the general practice in many settings. He states that oftentimes patients, in addition to being forced to reside on an impatient unit, are also required to participate in psychotherapy, and are routinely given psychotropic medication without consent. Further, he cites the use of involuntary ECT (electroconvulsive therapy) as a way of modifying behavior. Winnick cautions the reader as to the potential for abuse that such forced treatment can cause:

> Lurking in the background is the ominous specter of behavior control made possible by the coercive use of these techniques. When a society determines that an individual is mentally ill or is a criminal offender, it engages in a particularly strong form of deviance labeling. Such labeling often has the effect of depriving those so labeled of basic liberty. People determined to be mentally ill frequently are committed to psychiatric hospitals, and those convicted of crimes often are sentenced to prison. But so socially deviant are those the state labels as mentally ill and as criminals that it does not stop at labeling them and taking away their liberty. In addition, we try to change them through impositions of often intrusive treatment or "rehabilitation." For patients involuntarily institutionalized..... a thin line often separates treatment for mental illness from control of social deviance (pgs 5-6).

Nevertheless, Winnick (1997) states that more and more states are placing statutory limits on the coercive treatment of mental patients, most notably the state of California. Indeed, Winnick cites copious constitutional law that he believes may support, in the case of involuntary treatment, a violation of the Equal Protection Clause of the Fourteenth Amendment, which was designed to prevent not only discrimination based on race, but also to mandate that similar individuals be treated alike by the government. That clause, according to Winnick, could be interpreted in such a way as to apply to the coercive treatment of the mentally ill.

With respect to the future of the right to refuse treatment, ever the topic of hot debate, Winnick (1997) advocates the use of advance directives and advance planning. Indeed, Winnick states that the Supreme Court's landmark "right-to-die" case, *Cruzan v. Director, Missouri Department of Health* can apply not only to the terminally ill, but to the mentally ill who are faced with involuntary treatment as well.

> Rather than viewing treatment refusal issues as disputes requiring judicial or administrative resolution, the logic of *Cruzan* allows them to be seen as opportunities for advance planning, which in many cases may avoid dispute resolution..... Under *Cruzan*, patients are given an opportunity to express their desires about future treatment. Under these developments, patients are empowered to make decisions in advance concerning future health care needs arising at a time when they may be incapacitated..... This analysis of Cruzan and its implications suggest that mental patients during a period of competency should be able to make advance determinations concerning hospitalization and treatment issues. The due process liberty interest recognized in *Cruzan* would apply to all *persons*, the term used in the Due Process Clauses of both the Fifth and Fourteenth Amendments to describe the beneficiaries of their protection against governmental deprivation. Both those suffering from mental illness and those suffering from life-threatening medical conditions may exercise this liberty interest as long as they are competent at the time of the expression of choice, even though both may be incompetent at the time when that choice is given effect (pgs 391-393).

The bipolar pendulum of the rights of the mentally ill and their need for treatment has long moved between the two poles as dictated by the zietgeist of the times. As mentioned earlier, Darryl Treffert was a psychiatrist whose opinions paralleled those who advocated for the treatment, albeit sometimes mandatory, of the mentally ill. It was Treffert who made popular the phrase that described the civil libertarian movement as giving the mentally ill the freedom of "dying with their rights on" (Appelbaum, 1994). A second psychiatrist, who was also a professor of law and psychiatry at Harvard Law School, proposed what he felt was a balance between mandatory treatment and personal liberty with his "Thank You Theory" of civil commitment (Appelbaum, 1994). "Under this

approach, a set of criteria would be developed, emphasizing patients' need for treatment, incapacity to make their own decisions, and reasonable expectations that they might benefit from care, with the goal of identifying a group of patients who could reasonably be expected to be grateful, at the conclusion of their hospitalization, that commitment had occurred" (Appelbaum, 1994).

With regard to the movement for mandated treatment, Perlin (2000) writes:

> The existence of a statutory right to treatment was first judicially recognized by the District of Columbia circuit Court of Appeals in the unlikely setting of a habeas corpus case brought by an insanity acquittee. In *Rouse v. Cameron,* the court found that a District of Columbia hospitalization law established such a statutory right, reasoning that 'the purpose of involuntary hospitalization is treatment, not punishment,' quoting a statement by the act's sponsor that, when a person is deprived of liberty because of need of treatment and that treatment is not supplied, such deprivation is 'tantamount to a denial of due process.' The hospital thus needed to demonstrate that it had made a 'bona fide effort' to 'cure or improve' the patient, that inquiries into the patient's needs and conditions were renewed periodically, and that the program provided was suited to the patient's 'particular needs' (pg 115).

Perlin (2000) also speaks to what some consider the constitutional (not just statutory) right of mentally ill individuals to receive treatment:

> The most important case finding a *constitutional* right to treatment was, without doubt, *Wyatt v. Stickney.* Wyatt was clear: 'The purposes of involuntary hospitalization for treatment purposes is *treatment* and not mere custodial care or punishment. This is the only justification from a constitutional standpoint, that allows civil commitment to [a state hospital]....To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process.' It subsequently found three 'fundamental conditions for adequate and effective treatment': (a) a humane psychological and physical environment, (b) qualified staff in numbers sufficient to administer adequate treatment, and (c) individualized treatment plans (pg 115).

One of the central tenets of the debate surrounding involuntary commitment is the aspect of dangerousness. The issue of dangerousness was brought to the fore in the 1975 Supreme Court case of O'Connor v. Donaldson, in which Kenneth Donaldson sued the

hospital superintendent for depriving him of his freedom in the absence of any justification of dangerousness to others. Justice Steward, in his majority opinion, determined that "A finding of mental illness alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement" (Linburn 1998).

Even though trial testimony demonstrated that Kenneth Donaldson posed no danger to others, he was involuntarily committed to a Florida state hospital for almost 15 years, during which he repeatedly and unsuccessfully sought his freedom. According to Linburn (1998), "The evidence showed that Donaldson's confinement was a simple regime of enforced custodial care, not a program designed to alleviate or cure his supposed illness." As a result of O'Connor v. Donaldson, dangerousness became the salient standard on which civil commitment was based.

Some believe that the Donaldson decision had untoward consequences in that protection due to dangerousness was elevated but the need to treat the mentally ill downtrodden. Linburn (1998), notes that "The view that dangerousness is the critical justification for civil commitment has thus marginalized a central purpose of civil commitment—to provide care and treatment for the severely mentally ill. Emphasizing dangerousness has tended to criminalize such commitments by skewing the rationale in favor of the state's police power at the expense of it parens patriae responsibility" (to provide care for the mentally ill).

Another social scientist offers commentary on the debate when he states that "....concentration upon seeking the least restrictive alternative in patient care has meant that some patients and their families have been occasionally denied access to care" (Prins,

1996). Contrasting that with the other side of the debate, Prins also noted that, "There would seem to be some grounds for concluding that we should adopt a very cautious approach to an over-widespread use of the law in matters concerning the management of social and personal ills. In addition, a proliferation of procedures which accompany legislation may only serve to inhibit good practice and produce iatrogenic consequences. Somehow, a balance must be achieved between the view of Mr. Bumble, who described the law as 'a ass, a idiot' and the jurist Lord Coke, who considered that 'the law is the perfection of reason.'"

States have long struggled to find a balance between protecting the civil liberties of their mentally ill, while ensuring that opportunities for treatment (however mandated) are extended to those in need of such services. Aviram and Weyer (1996) offered a succinct conceptualization of the debate in the opening of their paper *Changing Trends in Mental Health Legislation: Anatomy of Reforming a Civil Commitment Law.* They wrote: "During the past twenty-five years, U.S. public policy involving civil commitment of persons with mental illness swung like a pendulum between two opposing poles: the medical-psychiatric and the legal models. The former emphasizes medical considerations of a person's need for treatment and allows easier commitment to psychiatric institutions; the latter focuses on legal procedural safeguards and protection of civil liberties during commitment proceedings and makes commitment more restrictive."

Aviram and Weyer (1996) highlight the evolving and often alternating trends of civil libertarian approaches and social service orientations in their paper, and note that the special interests of the parties shaping mental health legislation are often outside the mental health system.

The seemingly dichotomous positions of the rights of the mentally ill and their need for treatment will continue to be debated. But even with that debate ongoing, a third position, albeit separate but related, has emerged which represents another evolution of how we view those we term mentally ill, as well as the laws and dictates that govern their treatment.

Therapeutic Jurisprudence

Therapeutic jurisprudence represents a profound change from an era of Bedlam-type treatment of the mentally ill. It not only takes a compassionate view of those who are afflicted with mental impairment, but it also investigates the impact of relevant legal mandates on the same. David Wexler and Bruce Winnick (1996), two of the most prolific researchers in this area, explain the need for and utility of therapeutic jurisprudence: "The therapeutic jurisprudence heuristic suggests that the law itself can be seen to function as a kind of therapist or therapeutic agent. Legal rules, legal procedures, and the roles of legal actors (such as lawyers and judges) constitute social forces that, like it or not, often produce therapeutic or antitherapeutic consequences. Therapeutic jurisprudence proposes that we be sensitive to those consequences, and that we ask whether the law's antitherpeutic consequences can be reduced, and its therapeutic consequences enhanced, without subordinating due process and other justice values."

A full review of therapeutic jurisprudence is clearly beyond the scope of this paper. However, a brief look at its essence, especially as it pertains to involuntary commitment, will highlight just how far we've come from the days of chaining the mentally ill to their beds or spinning them in cages to alleviate their distress.

In one of their many publications, *Law in a Therapeutic Key,* Wexler and Winick (1996), carefully look at the psychological consequences of judicial procedures on those brought before the bar for a civil commitment hearing. They note the importance of "neutral fact-finding" in a procedure that has the potential of seriously curtailing individual freedom: "The identification of neutral fact-finding as the criterion against which to evaluate the adequacy of judicial hearings is consistent with the legal literature on procedures. *That literature typically focuses on issues such as bias, honesty, and expertise. These aspects are regarded as important because they are believed to influence the ability of a procedure to reach an objectively correct outcome. ....If the key concern in devising commitment procedures is determining the true mental state of the person in order to make the best decision about commitment, then this balance of authority should be shaped by evaluations of the capabilities of professional and judicial decision-makers.*" (italics added)

Wexler and Winnick (1996) summarize their research about what the mentally ill themselves think and feel with regard to civil commitment procedures. "People's evaluation of the fairness of judicial hearings are affected by the opportunities which those procedures provide for people to participate, by the degree to which people judge that they are treated with dignity and respect, and by judgments about the trustworthiness of authorities. Each of these three factors has more influence on judgments of procedural justice than do either evaluations of neutrality or evaluations of the favorableness of the outcome of the hearing."

When mentally ill individuals positively evaluate the process whereby they are constrained to receive help, they are more likely to benefit from that help, according to

Wexler and Winnick (1996). "If people become estranged from authority, distrusting others; believing that they are vulnerable, and hence feeling insecure; and lacking in feelings of self-worth, those consequences are disadvantageous and preferably could be avoided. Historically, many of these negative psychological consequences have occurred in the context of professional commitment hearings. Judicial hearings, which have been more sensitive to issues of due process, may have more positive psychological consequences. Ultimately, decisions about the desirability of different judicial procedures need to be responsive to both the objective quality of the decisions made and to the psychological consequences of varying types of decision-making procedures." Winnick notes that even though mandatory treatment may be necessary, as in the cases of those who are severely mentally ill, coercion should be avoided whenever possible because of its anti-therapeutic effects on the recipient (Winnick 1997).

Perlin (2000) also speaks to therapeutic jurisprudence. He concludes that it can be used as an effective tool to help those who are suffering from mental illness and who may be refusing treatment, and whose attorneys seek to represent their client's expressed interests:

> The empirical research done regarding the right to refuse treatment for mental health patients coupled with a survey of the practical implementation of this right indicates that patients' rights advocates and attorneys, in enforcing the right to refuse treatment, could benefit from using therapeutic jurisprudence. Therapeutic jurisprudence provides a tool to allow counsel representing mentally disabled persons to identify anti-therapeutic problems and to attempt to resolve these issues to enhance patients' civil rights in a therapeutic manner. Finally, therapeutic jurisprudence is a potential means for attorneys and advocates representing medication refusers to attempt to see how they can improve the quality of their advocacy to ensure that the expressed interest of their clients is represented (pg 285).

Other social scientists agree that the *process* whereby individuals are involuntarily detained impacts the detainee more than the actual detention. The psychological consequences of the judicial procedures themselves, asserts Tyler (1996), highly influence how the mentally ill view imposed restrictions on their freedom, and are highly relevant to the laws as they now stand.

While investigating the effects of civil commitment on involuntary patients, Kjellin, Anderson, Candefjord, Palmstierna and Wallsten (1997) found an association between perceived respect for autonomy by authorities and self-reported improvement in mental health. They noted that, "The aim of both involuntary and voluntary psychiatric care must be to achieve as many benefits as possible at the lowest [ethical] cost."

Therapeutic jurisprudence is not without its critics. Winnick and Wexler (1996), proponents of therapeutic jurisprudence have included in their book, *Law in a Therapeutic Key*, chapters that take a critical look at the idea of making the practice of mental health law more therapeutic. Perlin, Gould, and Dorfman (1996) critically review the concept in chapter 38 of Winnick and Wexler's book: "Indeed, one of the most important controversies that has emerged from the first generation of therapeutic jurisprudence scholarship is the question of whether, as a result of therapeutic jurisprudence, mental disability law will be more therapeutic or more jurisprudential. Some of the most important criticism of therapeutic jurisprudence flows from what is perceived as its willingness to subordinate civil libertarian concerns to therapeutic interests; at the same time, some of the enthusiasm that therapeutic jurisprudence has engendered may flow implicitly from the same assumption.

On the other hand, Wexler and Winnick recognize explicitly that therapeutic jurisprudence cannot and must not trump civil libertarian interests." Petrila, in chapter 34 of Wexler and Winnick's book, offers a different type of criticism. "[Therapeutic jurisprudence] fails to question *who decides* what represents a therapeutic outcome. Instead, [it] assumes that research scientists and lawyers will decide whether a particular legal rule or intervention has therapeutic value. People treated voluntarily or coercively by mental health professionals and subject to legal rules governing the conditions and terms of that treatment are largely ignored. As a result, people who can provide the best information about the therapeutic or anti-therapeutic consequences of legal/therapeutic interventions are excluded from participating in the analysis of what is or is not in their interest."

Unfortunately, there is a virtual lack of studies with respect to general inpatient outcome research and how the involuntary commitment process, and the client's participation therein, functions to predict therapeutic success or failure. However, Tyler (1996), while acknowledging the dearth of relevant studies in this area, points to other studies that have researched how people are typically affected by judicial hearings in an attempt to glean information applicable to involuntary commitment hearings and their outcome. Indeed, he cites three elements that are important determinants of how people judge procedural fairness. Those elements are participation, dignity and trust.

Tyler (1996) notes that individuals involved in judicial proceedings consistently view them as fairer when they have been allowed to participate in the same. Indeed, when one is allowed to speak or exert some control over the process of proceedings, and when one is allowed to share in decision-making, feelings of fairness are enhanced.

Interestingly, even when people believe that what they have to say about their situation has little or no influence over the person in authority, they still value that opportunity, even if such an opportunity occurs *after* a decision has been made. Next to participation, individuals faced with judicial proceedings place significant value on dignity (Tyler, 1996; Winnick, 1997). Indeed, Tyler (1996) notes that people "value the affirmation of their status by legal authorities as competent, equal, citizens and human beings, and they regard procedures as unfair if they are not consistent with that affirmation. To understand the effects of dignity, it is important to recognize that government has an important role in defining people's views about their value in society. Such a self evaluation shapes one's feelings of security and self-respect."

The third element that impacts how people respond to contact with the judicial system is trust (Tyler, 1996). Essentially, people want to see some evidence that the authorities with whom they are interacting have a basic concern about their welfare, and have a desire to treat them fairly. According to Tyler (1996), "Trust is the most important quality, but also the most elusive, because it involves a motive attribution. In other words, people must infer whether an authority is or is not motivated to treat them fairly based on that authority's actions." Not surprisingly, that trust is influenced by participation and dignity. Tyler asserts that, "People regard authorities who allow them to present evidence as more trustworthy. Similarly, people regard authorities who treat them with dignity and respect as more trustworthy. Finally, the efforts of authorities to explain or account for decisions heighten judgments of trustworthiness."

Tyler (1996) in *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence*, while acknowledging the lack of direct research, summarizes the

implications of the above elements of participation, dignity and trust as they apply to commitment hearings.

> The key question is what implications can be drawn from this literature regarding the therapeutic consequences of personal experiences with legal authorities. One implication is that people respond to how decisions are made—a response that is not simply linked to what decisions are. Hence, the psychological arena defined by the Supreme Court in cases such as *Goldberg v. Kelly* and *Morrissey v. Brewer* clearly exists.
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> Failure to receive due process has a number of negative consequences for people who have personal experiences with legal authorities, including reluctance to accept decisions, diminished respect for the judge, mediator, or other third party, diminished respect for the courts and the legal system, and a diminished willingness to follow legal rules. These effects are completely consistent with the suggestion that experiencing arbitrary procedures leads to social malaise and decreases people's willingness to be integrated into the policy, accepting its authorities and following its rules.
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> Of particular relevance to the question of therapeutic implications is the issue of behavior. Enhancing respect for authorities, the willingness to voluntarily accept the decisions of authorities and the willingness to follow social rules are core objectives of any therapeutic program. Hence, it seems likely that future studies of the therapeutic consequences of judicial hearings will demonstrate that commitment hearings experienced as unfair by those potentially being committed will have strongly antitherapeutic consequences (pgs 12-13).

Winnick, (1996) believes that therapeutic jurisprudence has the potential to mediate some of the possible negative effects inherent in involuntary commitment hearings as they are typically conducted presently. He says that, "Legal rules may produce negative psychological or behavioral consequences. The effort to assess the negative psychological and behavioral effects of legal rules and to suggest ways in which they may be minimized can be seen as an exercise in therapeutic jurisprudence."

Whether or not one believes therapeutic jurisprudence to be a viable reform of mental health law, it nevertheless stands in dramatic contrast to the centuries-past concern for the mentally ill. And regardless of whether one agrees with the reforms that

civil libertarians and those who seek to protect access to care have achieved, one could hardly argue against the fact that the present state of mental health law is far superior to the days when the mentally ill had no rights or protection under the law. Nevertheless, it is important to remember that involuntary commitment severely restricts one of our most fundamental human rights, that of freedom. Even so, it remains a highly protected issue that even the United States Supreme Court has been reticent to approach. Cornwell (1998) notes that:

> In 1972, the Supreme Court noted that it was 'remarkable' given the number of individuals affected by involuntary civil commitment to mental hospitals, that 'the substantive constitutional limits on these powers have not been more frequently litigated.' Whereas judicial activity increased in the years that followed, the Supreme Court has remained hesitant to encroach upon the authority of state officials to determine substantive standards for commitment. This phenomenon is a function, perhaps, of the power that states have traditionally exercised over the management of mentally ill persons and of the Court's concomitant recognition of the propriety of judicial deference to legislative determinations relating to the unsettled area of psychiatry (pgs 1-2).

Involuntary Commitment Diagnoses and Types of Treatment

And how many people are subject to involuntary commitment? In his 1981-1984 study of the Metropolitan Court in California (where civil commitments were held), Holstein (1993) observed the workings of the court in this regard. According to his observations, "...one temporary judge never granted a writ releasing a patient. In the other jurisdictions, commitment hearings usually—but not always—resulted in hospitalization; judges' informal estimates of commitment rates ranged from 60 to 90 percent" (pg 33). Cornwell (1998) cites Supreme Court statistics from 1961 that indicate that approximately 720,000 individuals judged mentally ill were, at that time, involuntarily committed. More recent statistics point to an increase in that number. Isaac and Brakel (1992) estimate that individuals civilly committed to psychiatric facilities for

treatment is roughly 1.2 million per year. Thus, some million plus mentally ill people are appearing before United States judges who have the responsibility to determine whether treatment will be mandated by involuntary commitment, or whether they will retain their freedom to not be confined in a psychiatric facility.

The disorders and diagnoses associated with involuntary commitment can be found in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV), (American Psychological Association, 1994). Essentially, any mental disorder, when accompanied by the commitment criteria of dangerousness to self or others, or an ability to take care of one's own basic needs as a function of a mental illness, can qualify a person for civil commitment. Nevertheless, certain disorders are consistently associated with involuntary commitment. Categorically, five of the most common are delirium and dementia disorders; substance-related disorders; schizophrenia and other psychotic disorders; mood disorders and; personality disorders. According to the DSM-IV, there are specific symptoms that characterize mental disorders. Following, is a breakdown of the essential diagnostic features that typify the five aforementioned categories as directly extracted from the DSM-IV.

Delirium and Dementia Disorders

The essential feature of a delirium is a disturbance of consciousness that is accompanied by a change in cognition that cannot be better accounted for by a preexisting or evolving dementia. The disturbance develops over a short period of time, usually hours to days and tends to fluctuate during the course of the day. The disturbance in consciousness is manifested by a reduced clarity of awareness of the environment. The

ability to focus, sustain or shift attention is impaired. Questions must be repeated because the individual's attention wanders, or the individual may perseverate with an answer to a previous question rather than appropriately shift attention. There is an accompanying change in cognition (which may include memory impairment, disorientation, or language disturbance) or development of a perceptual disturbance. Disorientation is usually manifested by the individual being disoriented to time or being disoriented to place. Perceptual disturbances may include misinterpretations, illusions, or hallucinations.

The essential feature of a dementia is the development of multiple cognitive deficits that include memory impairment and at lease one of the following cognitive disturbances: aphasia, apraxia, agnosia, or a disturbance in executive functioning. The cognitive deficits must be sufficiently severe to cause impairment in occupational or social functioning and must represent a decline from a previously higher level of functioning. A diagnosis of a dementia should not be made if the cognitive deficits occur exclusively during the course of a delirium.

Memory impairment is required to make the diagnosis of a dementia and is a prominent early symptom. Individuals with dementia become impaired in their ability to learn new material, or they forget previously learned material. Deterioration of language function may be manifested by difficulty producing the names of individuals and objects. Individuals with dementia may exhibit an impaired ability to execute motor activities despite intact motor abilities, sensory function, and comprehension of the required task. Further, they may be unable to recognize or identify objects despite intact sensory function. Impairment must be severe enough to cause significant impairment in social or occupational functioning and must represent a decline from a previous level of

functioning. Dementia is not diagnosed if these symptoms occur exclusively during the course of a delirium. However, a delirium may be superimposed on a persisting dementia, in which case both diagnoses can be given.

Substance –Related Disorders

Substance-related disorders include disorders related to the taking of a drug of abuse (including alcohol), to the side effects of a medication, and to toxin exposure. The term substance can refer to a drug of abuse, a medication, or a toxin. Substances are grouped into 11 classes: alcohol; amphetamine or similarly acting sympathomimetics; caffeine; cannabis; cocaine; hallucinogens; inhalants; nicotine; opioids; phencyclidine (PCP) or similarly acting arylcyclohexylamines; and sedatives, hypnotics, or anxiolytics. Many prescribed and over-the-counter medications can also cause substance-related disorders. Symptoms are often related to the dosage of the medication and usually disappear when the dosage is lowered or the medication is stopped.

Substance-related disorders are divided into two groups: the Substance Use Disorders (Substance Dependence and Substance Abuse) and the Substance-Induced Disorders (Substance Intoxication, Substance Withdrawal, Substance-Induced Delirium, Substance-Induced Persisting Dementia, Substance-Induced Persisting Amnestic Disorder, Substance-Induced Psychotic Disorder, Substance-Induced Mood Disorder, Substance-Induced Anxiety Disorder, Substance-Induced Sexual Dysfunction, and Substance-Induced Sleep Disorder).

Schizophrenia and Other Psychotic Disorders

The essential features of Schizophrenia are a mixture of characteristic signs and symptoms (both positive and negative) that have been present for a significant portion of time during a 1-month period (or for a shorter time if successfully treated), with some signs of the disorder persisting for at least 6 months. These signs and symptoms are associated with marked social or occupational dysfunction. The disturbance is not better accounted for by Schizoaffective Disorder or a Mood Disorder with psychotic features and is not due to the direct physiological effects of a substance or a general medical condition.

The characteristic symptoms of Schizophrenia involve a range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioral monitoring, affect, fluency and productivity of thought and speech, hedonic capacity, volition and drive, and attention. Characteristic symptoms may be conceptualized as falling into two broad categories—positive and negative. The positive symptoms appear to reflect an excess or distortion of normal functions, whereas the negative symptoms appear to reflect a diminuation or loss of normal functions. The positive symptoms include distortions or exaggerations of inferential thinking (delusions), perception (hallucinations), language and communication (disorganized speech), and behavioral monitoring (grossly disorganized or catatonic behavior.

Mood Disorders

Mood Disorders include disorders that have a disturbance in mood as the predominant feature. They are divided into the Depressive Disorders (unipolar

depression), the Bipolar Disorders, and two disorders based on etiology—Mood Disorder Due to a General Medical Condition and Substance-Induced Mood Disorder. The depressive Disorders (Major Depressive Disorder, Dysthymic Disorder, and Depressive Disorder Not Otherwise Specified) are distinguished from the Bipolar Disorders by the fact that there is no history of ever having had a Manic, Mixed, or Hypomanic Episode.

Major Depressive Disorder is characterized by one or more Major Depressive Episodes—at least 2 weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression, such as irritability, excessive crying, suicidal ideation or attempt, or increased or decreased appetite. Dysthymic Disorder is characterized by at least 2 years of depressed mood for more days than not, accompanied by additional depressive symptoms that do not meet the criteria for Major Depressive Disorder. Bipolar Disorder is characterized by one or more manic or mixed episodes and usually accompanied by Major Depressive Episodes.

Personality Disorders

There are 11 personality disorders noted in the DSM-IV. They include, Paranoid Personality Disorder, where there is a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent; Schizoid Personality Disorder, where there is a pattern of detachment from social relationships and a restricted range of emotion; Schizotypal Personality Disorder, wherein there is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior; Antisocial Personality Disorder, where there is a pattern of disregard for, and the violation of, the rights of others; Borderline Personality Disorder where there is a pattern

of instability in interpersonal relationships, self-image, and affects, and marked impulsivity; Histrionic Personality Disorder, wherein there is a pattern of excessive emotionality and attention seeking; Narcissistic Personality Disorder where there is a pattern of grandiosity, need for admiration, and lack of empathy; Avoidant Personality Disorder, wherein there is a pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation; Dependent Personality Disorder, where there is a pattern of submissive and clinging behavior related to an excessive need to be taken care of; Obsessive-Compulsive Disorder, wherein there is a pattern of preoccupation with orderliness, perfectionism, and control and: Personality Disorder Not Otherwise Specified, where the individuals personality pattern meets the general criteria for a personality disorder, but not all the criteria, or meets some of the criteria for more than one personality disorder.

Personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts. Only when personality traits are inflexible and maladaptive and cause significant functional impairment or subjective distress do they constitute a personality disorder. The essential feature of a personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture and is manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control. This enduring pattern is inflexible and pervasive across a broad range of personal and social situations and leads to clinically significant distress or impairment in social, occupational or other important areas of functioning. The pattern is stable and of long duration, and its onset can be traced back to

at least adolescence or early, and cannot be accounted for by another mental or medical disorder.

Typical Types of Treatment for Mental Disorders

As is the case with medical disorders, hosts of treatments exist for the treatment of mental disorders. Depending on the institution in which one is committed for treatment, and the theoretical positions of the treating staff, one could be offered, or unwillingly subjected to, a wide variety of treatments designed to impact the severity and course of a particular disorder. Bruce Winnick (1997) in *The Right to Refuse Mental Health Treatment* offers a detailed outline of the types of treatment available, their effectiveness, and their potential side effects. A brief summary of the basic characteristics of psychotherapy, behavior therapy, psychotropic medication and electroconvulsive therapy, describes the treatments typically available (whether by choice or judicial mandate) to civilly committed individuals.

Psychotherapy

According to Winnick (1997), "Psychotherapy is the generic term for any form of treatment based primarily upon verbal or nonverbal communication between a therapist and a patient in a structured professional relationship." Indeed, there are many forms of psychotherapy that can be delivered in either an individual or group setting. In a general sense, psychotherapy attempts to mediate the symptoms of a wide range of psychological disorders within the context of the client-therapist relationship. Traditionally, psychotherapy "seeks to influence the attitudes of patients toward their illnesses, their

own mental and physical processes, and their environment so that they may gain insight into the nature and cause of their problems" (Winnick, 1997).

With regard to the effectiveness of psychotherapy, as evidenced by empirical research, it is generally accepted that psychotherapy is beneficial. Partitioning out the change-inducing effects of psychotherapy remains a challenge for social scientists. Nevertheless, certain characteristics or common factors have been isolated as fundamental to the process of change. Hubble, Duncan and Miller (1999), elaborating on the work of Jerome Frank, and later Michael Lambert, and using a wide variety of research designs estimated that client and extratherapeutic factors account for 40% of outcome variance, with relationship factors accounting for 30% of outcome variance. Placebo, hope and expectancy accounted for 15% of the variance, and model and technique factors 15%.

Behavior Therapy

Winnick, (1997) describes behavior therapy as the "clinical application of experimentally derived principles of psychological learning theory to teach adaptive behavior or modify maladaptive behavior by means of systematic manipulation of the patient's environment." He notes that behavior therapy is based on the principles of learning and reinforcement as well as conditioning. Based primarily on the groundbreaking work of Pavlov, Skinner, Thorndike and others, behavior therapy seeks to change the contingencies whereby certain behaviors are reinforced. An example of this is a technique called a "token economy" wherein certain behaviors are "rewarded" and others "punished." Winnick highlights the acceptance of behavior therapy as a viable

form of treatment: "Evidence of its general acceptance and increasing influence can be found in the emergence since 1963 of at least 15 new research journals devoted to behavior therapy, the widespread availability of courses in behavior therapy in psychology doctoral programs, medical schools, and psychiatric residency programs; and the dramatic growth in government-funded research devoted to this rapidly developing field."

Despite its popularity, Winnick (1997) is careful to note that behavior therapy can pose a potential for abuse. Indeed, "Token economies and tier systems, for example, sometimes make meals, a bed, toilet articles, outdoor exercise, writing and reading materials, religious services, and other basic personal requirements available contingent on the patient behaving in conformity with program goals." Further, when one considers the hosts of individuals potentially responsible for implementing a behavior therapy regimen, the abuse or inappropriate use of behavior modification principles becomes a concern.

Psychotropic Medication

The use of pharmacology for the treatment of mental disorders is founded in the medical model. Medicinal treatments for mental pathology seek to influence biological/physiological processes rather than psychological ones. The early development of antipsychotics and antidepressants came about largely as a result of scientists noting the sedating or antidepressant effect of drugs prescribed for other medical problems. Early psychopharmacologic agents have been improved upon and, in many cases, the negative side effects of first generation antipsychotics and antidepressants have been

dramatically reduced. Indeed, effective medicinal treatments exist for many psychological disorders without the long list of debilitating side effects so common to their predecessors. Today, the use of antipsychotics, anxiolytics, tricyclic antidepressants, selective serotonin reuptake inhibitors, monoamine oxidase inhibitors, and many more is quite common in the treatment of mental pathology. Nevertheless, as with most pharmacological agents, side effects still exist and the use of drugs to treat mental disorders is not without certain risks. Some of the drugs can cause fatal allergic reactions, debilitating blood and liver disorders, and even death. Still others have the potential to cause symptoms that, although non life-threatening, are both horrific and irreversible (Winnick, 1997).

> Although these drugs are demonstrably effective, their use is often accompanied by toxic reactions and adverse side effects, some of which are quite serious and irreversible. Most of the antipsychotic and antidepressant drugs produce a family of autonomic side effects, including blurred vision, dry mouth and throat, constipation, paralytic ileus, urinary retention, orthostatic hypotension, edema, tachycardia, palpitations, dizziness, faintness, drowsiness, fatigue, and inhibition of ejaculation.
>
> The most common side effects of the antipsychotic drugs are the extrapyramidal reactions, a family of bizarre disorders of the extrapyramidal motor system, consisting of a Parkinsonian syndrome, akathisia, dystonia, and dyskinesia. The Parkinsonian syndrome, closely resembling the symptoms of Parkinson's disease, consists of muscular rigidity, fine resting tremors, a masklike face, salivation, motor retardation, a shuffling gait, and pill-rolling hand movements. Akathisia is a feeling of motor restlessness or of a compelling need to be in constant motion in which the patient has difficulty remaining still and is driven to pace about impatiently and tap his foot incessantly. Dystonia involves bizarre muscular spasms, primarily of the muscles of the head and neck, often accompanied by facial grimacing, involuntary spasm of the tongue and mouth interfering with speech and swallowing, oculogyric crisis marked by eyes flipping to the top of the head in a painful upward gaze persisting for minutes or hours, convulsive movements of the arms and head, bizarre gaits, and difficulty in walking. The dyskinesias present a broad range of bizarre tongue, face and neck movements. These extrapyramidal symptoms are subjectively quite stressful, may be incompatible with clinical improvement and with a useful life outside the hospital, and can be more unbearable than the symptoms for which the patients was

> originally treated. The psychotropic drugs, although efficacious in the treatment of many mental patients, thus present serious risks, particularly when involuntarily administered to institutionalized patients (pgs. 72-85) (Winnick, 1997).

Electroconvulsive Therapy

Another effective modality of treatment for certain mental disorders is electroconvulsive therapy (ECT). ECT consists of placing electrodes on the temples of the receiving patient (while under general anesthesia) and passing low doses of electrical current through the brain. Such a procedure produces convulsions in the patient that resemble a grand mal seizure much like in epilepsy, except that the paralytic agents administered prevent the body from actually seizing. It is unclear, at this time, just why ECT is an effective treatment of certain mental disorders, the most notable of which is profound, treatment resistant depression. Nevertheless, ECT is accepted as an efficacious treatment for certain conditions (Winnick, 1997).

Unfortunately, there are specific risks and complications associated with ECT, even though they have been significantly reduced over time, as the treatment has been refined. Because of the use of muscle relaxants, some patients experience a temporary cessation of breathing, chest wall spasms, coughing, spasms of the larynx, cardiac irregularities, or allergic reactions to the drugs. The most serious and typical side effect of ECT is confusion and memory loss. Nearly all patients who receive ECT are confused following the procedure, and lack memory of the hours surrounding the procedure. Other patients experience longer-term memory loss that has been reported to last from several weeks to permanently. The exact amount of memory loss is frequently disputed, but an amount of retrograde and anterograde amnesia is almost always present following ECT. This

memory loss may have a tendency to increase as the amount of ECT sessions (typically 4-12 treatments) increases (Winnick, 1997).

The fact that so many effective treatments exist for those suffering from mental disorders is heartening, and offers hope to many. Nevertheless, as outlined above, psychological treatment is not without certain risks. Further, when one considers some of the potential consequences (or side effects) of treatment for mental pathology, the fact that these treatments can be mandated on an involuntary basis, prudence dictates both caution, as well as strict adherence to the laws designed to protect the rights of the mentally ill who may be civilly committed to treatment. As such, judges who preside over involuntary commitment hearings have the ultimate responsibility of insuring the protection of those rights.

Judges and Their Involuntary Commitment Decisions

Prior to initiating the research at hand, a pilot study was conducted by the author in the state of Oklahoma to determine the extent of training Oklahoma's mental health judges had in abnormal psychology and mental health law. Further, the study investigated the judges' conceptualizations of the process of civil commitment and their opinions as to the appropriateness of judges making involuntary commitment decisions, given their educational preparation (Poyner, 2000 unpublished). This survey study was broken down into the judges' responses to questions from five related domains: 1) The importance of information sources (the mentally ill person's presentation in court vs. a doctor's statement) on decision-making; 2) Perceptions of adequacy of information on which decisions are made (treatment facility records); 3) Confidence in decision making, and

need for procedural changes; 4) Their general approach to commitment hearings (parens patriae or adherence to the law); and 5) Their educational preparation to make involuntary commitment decisions (how many courses taken in abnormal psychology and mental health law).

The results of that study showed positive correlations between the importance of information and the judges' confidence in their decision-making, as well as between the importance of information presented and the judges' general approach to commitment proceedings. A multiple regression suggested that judges who have been practicing longer tend to weight the clinical presentation of the patient as more important in their decision-making than do those judges who have been practicing for fewer years. Results also suggested that many judges believe that they are insufficiently trained to make mental health decisions, that they continue to use a basically paternalistic (parens patriae—what is best for the person or society) style in decision-making, and that the involuntary commitment process is non-adversarial as it is practiced in their courtrooms.

Bursztajn, Gutheil, Mills, Hamm and Brodsky (1986) also conducted a study where judges' commitment decisions were analyzed. They found that of 41 patients, the commitment rate was 83% (34 individuals). The judges in the study reported that their decisions were not difficult, and indicated that the three factors that most influenced their decisions were whether the psychiatrist's opinion was convincing; whether the patient would be a reliable outpatient; and whether the patient was able to take care of him or herself. Other factors that were found to influence the judges' decisions were the violence of the patient, the suicidality of patient, and the judges' own opinions about the patient's state.

Many social scientists have studied the practice and process of involuntary commitment. One of those scientists wanted to determine the correlates of patient characteristics and commitment status (Nicholson, 1986). He looked at commitment studies that researched such individual characteristics such as age, gender, race, economic resources, marital resources and education. With regard to behavioral characteristics, Nicholson also included a quantitative review of studies that included previous treatment, danger to self, danger to others, severity of disorder, negative attitude and disruptive behavior in hospital. Nicholson found that committed patients were, on average, older, male, and nonwhite when compared to non-committed patients. Further, civilly committed individuals were less educated, and had fewer marital and economic resources than voluntary patients. Across the studies he evaluated, Nicholson also found that committed patients had more severe symptoms, received more serious diagnoses, and showed more dangerous behaviors than those who were voluntarily admitted.

Another researcher also investigated race as a factor that appears to play a part in involuntary commitment decisions (Rosenfield 1984). Specifically, she researched race and civil commitment. She analyzed data from a random sample of 666 individuals who presented to a large New York City psychiatric emergency room. Using hospitalization vs. non-hospitalization and voluntary vs. involuntary as outcome criteria, Rosenfield found that whites and nonwhites did not differ in their likelihood for hospitalization. However, she found that nonwhites were significantly more likely than whites to be *involuntarily* hospitalized. Linsky (1968), in another study, also found that the ratio of involuntary to voluntary commitment is higher for nonwhites than it is for whites.

Haney and Michielutte (1968) found very selective factors that combined to influence the adjudication of incompetency—often the forerunner to involuntary commitment. Indeed, this team found that older people were declared incompetent more often than young people, and that when psychiatrists comprised the committee for determination of incompetency, there were more determinations of the same. They also found that specific demographic analysis points to the determination of incompetency more often in urban, than in rural courts. Haney and Michielutte concluded that non-legal and non-medical factors often play a significant part in the incompetency and often subsequent involuntary commitment of mentally ill individuals.

Rushing (1971) also found that certain variables influence the rate of involuntary vs. voluntary hospitalization. Occupation was found to be one factor that correlated more highly with involuntary, than voluntary, hospitalization for mental illness. Indeed, laborers were admitted to psychiatric services on an involuntary basis at almost twice the rate of voluntary admissions, whereas those in professional occupations were voluntarily and involuntarily admitted at essentially the same rate. Single people were also involuntarily admitted twice as often as voluntarily admitted, whereas married people were voluntarily admitted almost equally to involuntarily. Socioeconomic status played a part as well. The lowest socioeconomic group was involuntarily committed to treatment much more often than those of higher socioeconomic classes. The authors of this study concluded that, "a person's social and economic resources and degree of community integration appear to be significant contingencies in the tendency to involuntarily hospitalize"(pg524).

Surely, no one can dispute the fact that involuntary commitment decisions are both complex, and rife with political and societal implications. The decision to take away one's freedom and liberty, however temporarily, cannot be made lightly. Prudence, therefore, would dictate that those tasked with decisions of such paramount importance would be highly prepared, both educationally and experientially. Unfortunately, such does not appear to be the case.

The judges in the author's pilot study (Poyner, 2000 unpublished) reported that the number of courses they had taken in abnormal psychology ranged from 0-15, with a mean of 1.175, and a standard deviation of 2.50. In terms of the number of courses taken in mental health law, the judges ranged from 0-10, with a mean of 1.214, and a standard deviation of 1.961.

It is also important to compare the low level of training in abnormal psychology and mental health law that the judges reported with their reported confidence (62%) that their decisions are legally sound. When one considers the complex nature of most mental illnesses, the question most salient here is how judges can determine that a person should be involuntarily committed to treatment, without specific training in mental health law, as well as the symptomotology, etiology, and predicted course attendant to a given mental disorder. Training in this area would seem crucial to effective, fair, and reasonable decision-making. One judge made the following notation on his survey, "....there should definitely be training for judges in this area!" (Poyner, 2000 unpublished).

Another area of interest is the judges' responses in the author's pilot study (Poyner, 2000 unpublished) concerning their likelihood to involuntarily commit mental health patients even when they do not present as a danger to themselves or others, or as unable

to care for their basic needs, when the law stipulates those areas as the specific criteria for commitment. Over 50% of the judges indicated that they would be somewhat likely to extremely likely to involuntarily commit an individual even when their presentation pointed to an absence of the criteria needed for commitment, if the doctor's statement stated otherwise.

If a large proportion of judges are typically deferring to the doctor's written statement, again, one has to question the purpose of having mentally ill individuals appear before a judge. Additionally, as noted above, a good proportion of the judges (19%) noted that the doctor's statement is extremely to somewhat *unimportant* to their decision-making. That combined with the judges (22.2%) who reported that the patient's clinical presentation is somewhat or quite *unimportant* to their decision to commit, again begs the question of what rationale is being used for these important decisions.

The judicial system as a whole is noted for its adversarial process, and as such, it offers those who appear before a judge an attorney who will represent their interests. In the pilot study preceding this one, over 22% of the judges indicated that the involuntary commitment hearings carried out in their courtrooms are somewhat, quite, or extremely *non-adversarial.* These positions invite questions with regard to why mental health patients are not provided with the same adversarial processes as those citizens accused of crimes.

To truly protect the interests and rights of the mentally ill, an adversarial process should be deemed highly important, and necessary to the involuntary commitment process. Only judges are in a position to insure that the mentally ill individuals appearing in their courtrooms are assisted by attorneys who will genuinely represent them and

advocate their position. In criminal trials, a lack of appropriate representation can be cause for a mistrial. In mental health hearings, however, there is no provision for such a safeguard. One judge offered his opinion about the premise that mental health hearings should be adversarial when he wrote, "This does seem to be an area of law that doesn't quite fit in the adversarial system. I often find both attorneys trying to work toward what they each believe is in the best interest of the patient and or society, rather than their assigned responsibility."

Other comments about the civil commitment process from the judges who responded to the pilot study included:

"I fear that the doctors have not evaluated the patient. Too many times, the patient has not seen the doctor, or if at all, only for a very short time. On some doctors, if the jury was not told who the doctor was, it would have a most difficult time determining which one needed treatment."

"So called independent evaluations are more reflective of ease of care, bed availability, and professional jealousies as privatization balloons costs consuming limited resources."

"More input [is needed] from the doctors. Now all we get is a form with signature: no reasons, no facts at all."

"Certification reports are entirely conclusory—no stated rationale behind conclusions. Accepting the reports assumes both doctors did their job in evaluation. I know recommendations for involuntary commitment are resource driven."

Other responses to the author's study suggest that a "parens patriae" approach may still be in effect for a good portion of the judges surveyed. With 42.8% of the responding

judges indicating that, aside from legally mandated criteria for involuntary commitment, they still base their decisions on personal opinion about what is best for the patient, a strong "parens patriae" approach is suggested. This calls into question the progress we've made in reducing the paternalistic approach to involuntary commitment. Similarly, almost 40% of the judges noted that they base their decisions to involuntarily commit on personal opinion, aside from legal criteria, as it pertains to what is best for society. Again, this calls into question how far we've come in better objectifying the process of civilly committing those who are suffering from mental illness.

Overwhelmingly, the judges surveyed in the author's pilot study (90.5%), believed that involuntary commitment decisions should continue to be made by judges. One judge offered her opinion of this debate when she wrote, "I do not believe that psychiatrists should make commitment decisions. I have released patients against Dr.'s recommendations because their conditions did not meet statutory definitions. I have found that the Dr.'s would let their feelings of what's best for the patient more often interfere with statutory requirements than would judges." Another judge offered an opposite opinion, "I believe judges and the court system are ill-equipped to make such decisions. [It] should be a doctor's decision, with appeal rights."

Another area that calls into question the judges' overall satisfaction with the involuntary commitment process, is whether or not the judges feel the system needs no change. The judge's in the author's study on average noted that they *disagreed* that the involuntary commitment process needs no change. Distribution wise, 52.4% of the judges disagreed with that premise. Overall, the judges were about equally divided about the

process needing or not needing change. A summary of typical comments about the overall process included:

1. Doctors should improve their handwriting and use plain English.
2. Doctors should offer thoughtful diagnosis and treatment.
3. Doctors should give more input to the judges.
4. Time constraints on how quickly the hearings are held should be examined.
5. Mental health statutes should be less vague.
6. The option of a jury trial should be eliminated. "Juries consistently commit. Judges do not."
7. Department of Mental Health "bureaucrats" should not interfere with the process.
8. Doctor's should appear at hearings.
9. More resources are needed for both evaluation and treatment.
10. Treatment plans should be provided to the judges to aid in decision-making.
11. Mechanisms need to be in place to insure rights are afforded to patients.
12. The forms for involuntary commitment are poorly drafted.
13. There is a great need for long-term treatment. "We see the same people over and over again."
14. Video conferencing from hospital to court may alleviate the patients' fears about being in court.

A substantially high number of the judges in the author's study (91%) agreed that when they involuntarily commit a mental health patient, they are generally confident that the process has been carried out in such a manner that the rights of the individual have been protected. However, one has to compare this finding with other responses, which

suggest that many of the judges are using a paternalistic approach to involuntary commitment, that many of the judges find the process non-adversarial, and that the judges appear to be poorly trained in the areas of mental health law and abnormal psychology.

The above results prompted the current study and provided the impetus to discover just how adequately judges are educationally prepared to make civil commitment decisions and to carry out the statutory requirements of mental health law. To understand the laws surrounding involuntary commitment, it would be prudent for the reader to be familiar with what those laws entail. Following is a brief overview of Oklahoma's Mental Health Statute. The laws in most states typically mirror this example.

Oklahoma Mental Health Law

The Department of Mental Health and Substance Abuse Services publishes and disseminates the Emergency Detention Manual & Guidelines for the state of Oklahoma (DMHSAS, 1997). The introduction of the manual sums up the purpose and intent of Oklahoma's mental health law as it applies to emergency detention.

> The purpose of the Oklahoma Mental Health Law is to provide for the humane care and treatment of persons who are mentally ill or who require treatment for drug and alcohol abuse. All such residents of this state are entitled to medical care and treatment in accordance with the highest standards accepted in medical practice.
>
> There are circumstances which justify the taking of an individual into protective custody for the purposes of initiating emergency detention proceedings. The emergency detention proceedings should be initiated only when there are no other acceptable alternatives for individuals who appear to be in need of treatment for mental illness or substance abuse. The emergency detention process is designed to ensure an individual receives appropriate treatment in addition to protecting the individual or other persons from dangers resulting from the mental illness or substance abuse.

> Protective custody and emergency detention are utilized as temporary measures for the speedy processing of emergency situations with the objective of suppressing and preventing conduct which is likely to create a clear and present danger to the individual or other persons. Emergency detention must not be utilized merely as a convenience to the parties involved in a particular situation. Under the police powers of the state, the right to initiate an emergency detention has been upheld by the courts. However, protective custody, emergency detention, and involuntary commitments deprive individuals of their liberty and should not be taken lightly. Therefore, constitutional due process is afforded to individuals subject to the emergency detention process. The due process includes, but is not limited to, the right to notice, the right to counsel, the right to jury trial, the right to be present in the hearing, the right to present and cross-examine witnesses, and the right to challenge detention through a habeas corpus action.
>
> It is the responsibility of law enforcement, the judicial system (judges, prosecutors, and defense attorneys), and mental health professionals to ensure that individuals falling within the jurisdiction of the Oklahoma mental health laws are afforded their constitutional and statutory rights (pg 7).

As with most legal documents, the laws that govern the judicial process afforded to those who face involuntary detention are copious and extensively worded. Indeed, the length of the document suggests that a great deal of thought and effort was put into determining the best way to protect the rights of the mentally ill and remain in compliance with state and federal law. Nonetheless, the basics of Oklahoma's most salient emergency detention laws, and the associated rights of those facing them, can be briefly summarized by the following:

1. A person placed in protective custody must be examined by a licensed mental health professional within 12 hours of being taken into custody to determine if emergency detention is warranted.
2. If emergency detention is warranted, the licensed mental health professional shall prepare a statement describing the findings of the examination and stating the basis for the determination. The statement will be in the form provided by the Department of Mental Health and Substance Abuse Services.

3. The licensed mental health professional shall provide for a full examination and evaluation of the person by two licensed mental health professionals.
4. A person may be detained in emergency detention more than 72 hours only if the facility is presented with a copy of an order of the district court authorizing further detention.
5. If a copy of an order for further detention is not delivered to the facility by the end of the period of emergency detention, the person requiring treatment shall be discharged unless said person has applied for voluntary treatment.
6. The person alleged to be mentally ill has the following rights: right to notice, right to counsel, right to a hearing, right to a jury trial if requested, right to be present at the hearing or trial and the right to present and to cross-examine witnesses.
7. The attorney appointed by the court for persons who have no counsel shall meet and consult with person within one day of the notification of the appointment and shall present to the person their rights as stated by the Oklahoma and United States constitutions.
8. If the person is found at the hearing to be mentally ill and requiring treatment, the court will take evidence and make findings of fact concerning the person's competency to consent or to refuse the treatment that is ordered, including the right to refuse psychotropic medications.
9. The person delivering the copy of the notice and petition to the person alleged to be mentally ill shall, at the time of delivery, explain the content, purpose and effect of the notice and the legal right to judicial review by habeas corpus.

10. A copy of the notice and the petition shall be delivered at least one day prior to the hearing to: the individual initiating the request for protective custody; the attorney representing the alleged mentally ill person; the district attorney; the facility in which the person is detained; the Department of Mental Health and Substance Abuse Services; and a parent, spouse, guardian, brother, sister or child of the person alleged to be mentally ill who is at least 18 years of age and who did not initiate the petition.
11. The notice may be served personally or by certified mail.
12. The period of prehearing detention shall not exceed 72 hours, excluding weekends and holidays. Prehearing detention may be extended to coincide with any order of continuance entered by the court.
13. The court, at the hearing on the petition, shall determine by clear and convincing evidence whether the person is a mentally ill person and a person requiring treatment.

Are the Current Laws Really Practiced?

With the basics of Oklahoma's emergency detention law outlined, it is time to turn to whether those laws, and others like them, are carried out—whether the spirit and the letter of the law coincide in any meaningful way. And that leads us to the question of whether the rights of the mentally ill truly are protected under the law as it is currently written and practiced, and whether judges are adequately prepared to make civil commitment decisions based on the statutory requirements of the law.

There are those who maintain that current judicial mandates adequately protect the rights of those mentally ill who have fallen under the purview of mental health law. In his

paper on the subject, one sociologist stated: "Compulsory detention in a psychiatric hospital constrains, but does not remove the rights of those admitted. The mental health laws of different countries provide for various mechanisms intended to protect the rights of detained patients" (Barnes, 1996). Others, even while acknowledging years of reform, disagree.

Perlin (2000) notes that the rights of the involuntarily committed individual may be abrogated by many people in the process of civil commitment--even staff members of inpatient psychiatric units.

> .....staff often view hospitalized patients who attempt to assert their constitutional and statutory rights as trouble makers, and thus privilege quietly compliant patients and subordinate 'difficult' patients. This becomes even more important (and troubling) when considering the power that hospital staff frequently have over patients' access to their counsel. If an institutionalized patient wants to contact counsel, she or he frequently must ask ward line-staff personnel to place the necessary telephone call. If, for whatever reason, the staff member determines that this is inappropriate, for example, if the patient is labeled a troublemaker—the promise of counsel becomes little more than a hoax (pg. 89)

Perlin, Gould and Derfman (1996) cite case law that found that the same "fundamental liberties" in criminal cases are at stake in civil commitment proceedings. And yet, the authors point out, "....traditionally, involuntary civil commitment procedures have not assured the due process safeguards against unjustified deprivation of liberty that are accorded those accused of a crime." Moreover, they state that "For those with mental disabilities, there is a dearth of competent counsel." Perlin et al. attributed this to ignorance of the law, fear of their clients, and feeling responsible for the acts of their clients. As a result, they note that attorneys do not "zealously" represent their mentally ill clients, and instead represent "what they—the attorneys and the advocates—feel is in the client's best interest or in society's best interest."

Such "best interest" representation is at the heart of "*parens patriae*"—a legal power used by states to justify their decisions to involuntarily detain or commit mentally ill individuals. Some feel that the parens patriae power is broadly used to also label the mentally ill as when, in the process of civil commitment, individuals are labeled incompetent. Winnick (1996) advocates a more limited use of parens patriae in the area of competency. "The adverse effects of incompetency labeling are sufficiently serious that in many contexts, application of the label should be regarded as a deprivation of liberty within the meaning of the Constitution. As a result, in such contexts, the state's ability to use its parens patriae power, which requires labeling an individual incompetent, should be limited. In these contexts, constitutional considerations suggest that incompetency should be defined more narrowly, that competency should be presumed, and that the burden of persuasion should be placed on the party that asserts incompetency."

James Holstein (1993) extensively researched the process of involuntary commitment. Indeed, from 1981-1984 he was a physical presence at the Metropolitan Court in California, observing and taking notes on the process of civil commitment. With regard to adherence to statutory mandates, he writes of his experience:

> While the law states that the *treating psychiatrist* must offer testimony regarding the patient's mental condition, this is often not the case in Metropolitan Court. Most of the persons filing writs were held in large local psychiatric facilities and several might have hearings in Metropolitan Court each day. If the law were to be strictly observed, each patient's treating psychiatrist would have to accompany the patient to court, and might spend the entire day waiting for the case to be called. Consequently, staff psychiatrists at the facilities typically agreed among themselves to testify in hearings involving patients for whom they were not the treating psychiatrists, thus limiting the number who had to go to court, and preserving the clinical schedules at their institutions.

> The testifying doctors had access to patient records and may have been familiar with the patients, their diagnoses, and treatment histories and plans before the day of their court appearances. At minimum they would review the psychiatric records, and attempt to briefly interview the patient, often in the halls of the court building itself. The PD's [Public Defender's] office stipulated that the presence of treating psychiatrists could be waived in order to allow the psychiatric facilities to remain adequately staffed. Thus, the proceedings at Metropolitan court might involve a single psychiatrist from the state hospital, for example, who would testify in the hearings of several patients—none of whom might actually be under his or her care (pg 32).

Indeed, Holstein quotes Warren (1982) as suggesting that, "commitment hearings are public occasions where justice is 'seen to be done'" (pg 42).

Other researchers cite problems with the implementation of current involuntary commitment laws. Husted and Nehemkis (1995) studied civil commitment from the perspectives of police, professionals, and families and found that "there is a difference in the subjective understanding of the criteria as delineated in the law. This is demonstrated by the fact that the two main groups who are responsible for initial implementation of the laws—emergency room mental health staff and police officers in the community, significantly disagree on when these laws may be applied."

Others note that even when it is clear that the law needs to be applied, it may be done so in the direction of commitment, but not in the direction of protecting the rights of those being committed. Osuna, Cuenca, Perez-Carceles and Luna (1995) addressed the legal status of the chronically ill and noted that "The spirit of the current legislative framework is to protect persons with mental illness and to guarantee each and every one of their rights. However, it should be recognized that promulgation of a new law is not tantamount to its enforcement."

Appelbaum (1997) in *Almost a Revolution: An International Perspective on the Law of Involuntary Commitment*, took an international look at involuntary commitment laws

and said that, "The key to understanding the difference between commitment law on the books and commitment law in practice is to recognize that laws are not self-enforcing. Indeed, implementation of involuntary hospitalization is delegated to a variety of participants in the commitment process, all of whom have the potential to affect how the law is applied. When the results of a law narrowly applied will be contrary to the moral intuitions of these parties, they will act at the margins to modify the law in practice to achieve what seem to them to be more reasonable outcomes" (pg 142).

Applebaum's (1997) contentions are supported by several pertinent studies. In one study, even though the very narrow terms of California's commitment law were not met, Warren (1982) found that one judge applied "commonsense notions to his decisions." In another study Hiday and Smith (1987) found that "in 47.5% of commitment cases in which the petition lacked any information concerning the statutory dangerousness criteria, respondents were committed anyway." Applebaum (1997) contends that failure to abide by commitment laws is also a problem for attorneys who represent the mentally ill. Indeed, Poythress (1978) who trained lawyers in challenging expert testimony at commitment hearings, found that "none of them used the training, because they did not see it as their job to achieve the release of people whom they viewed as genuinely ill." Other studies have had similar findings. Warren (1982) found that attorneys "were not often playing the adversarial role anticipated by the law." Bottomley (1987), found that "many lawyers.....elect to argue for their version of patients' needs rather than for patients' expressed wishes to be released. Lawyers' presence does not guarantee an adversarial proceeding."

Applebaum (1997) notes that the problem does not just rest with legal participants. "With judges and lawyers who are trained to be respectful of individual rights bending the law when that seems to be necessary for patients to receive treatment, it is no surprise that psychiatrists, whose primary interest is in providing treatment, do the same. Reviews of commitment petitions completed by psychiatrists and other mental heath professionals routinely reveal a failure to specify legally required criteria in a large percentage of cases: 16.1% in a North Carolina study of cases that led to judicial commitment; even higher numbers in a set of Canadian studies" (Hiday & Smith, 1987; McCready & Merskey; Page & Yates 1973, as cited by Applebaum).

Rubin, Snapp, Panzano and Taynor (1996) found that there are many factors which influence the implementation of mental health law, and that these factors may vary within individual states operating under the same legal code. Some of the factors include: judges' interpretations of the legal code; clinicians' attitudes about involuntary treatment; judges' attitudes about outpatient commitment as an alternative to involuntary hospitalization; service providers' liability concerns; the organizational structure of the local mental health delivery system; attorneys' assumptions of adversarial versus paternalistic positions in the courtroom; law enforcement officials' levels of cooperation; and the communities' demographic characteristics.

Bursztajn, Hamm and Gutheil (1997) have also looked at which factors influence the implementation of civil commitment laws. In a single case study of a judge's decision process and concomitant implementation of the law surrounding civil commitment, it was found that the judge considered factors not directly specified by the law. "Among the specific factors this judge used in considering whether the law's general principles

applied in each case, were the patient's competence, predictability, and reliability as an outpatient, as well as whether family and friends favor commitment."

Certainly, the medico-legal decision to involuntarily commit a person to treatment is not an easy one. Anderson and Eppard (1995) studied psychiatrists, nurses and counselors with regard to clinical decision making during assessment for involuntary psychiatric admission and identified nine structural elements: "The process of clinical decision making for involuntary psychiatric admission is systematic, cautious, and individualized. It is important to connect with the client and use intuitive reasoning. State-mandated criteria must be met, and treatment alternatives considered. All contingencies cannot be controlled. The decision to involuntarily admit a patient is never made alone." The preceding criteria appear to meld well with both the spirit and the letter of our current laws, which mandate a thorough, well-documented process that includes procedural safeguards to protect the rights of those most intimately affected by commitment decisions. Eriksson and Estrin (1995) though, found that the patients they surveyed felt a sense of "fait accompli" with regard to the coercive measures involved in the commitment process. Indeed, 51% of the surveyed patients who were committed reported that "they had been violated as a person/human being."

Oklahoma, like many other states, has seen lawsuits related to issues surrounding the detention of the mentally ill. One such lawsuit was explored in the *Opinions of the Oklahoma Supreme Court* (1997), and is officially known as Wofford vs. Mental Health Services, Inc. Court records show that Dawn Wofford was feeling suicidal on the night of October 29, 1990, and subsequently voluntarily admitted herself to Parkside Hospital. Earlier in the evening she had been refused admission at another hospital because of a

lack of insurance. As part of the admission process at Parkside, Mrs. Wofford signed a consent form that stipulated the conditions of her voluntary discharge from the hospital. Her signature acknowledged that to be released, she would be required to submit a written request to the administrator and the medical director of the hospital, and that the hospital would be allowed to hold her for only 3 days after her written request.

Approximately 12 hours after her admission, Ms. Wofford requested, in writing, that she be released from Parkside Hospital. On November 2, 1990, 4 days after her admission, an order allowing Parkside to detain Ms. Wofford was filed with the court. Mrs. Wofford responded by filing a writ of habeus corpus, after which the hospital released her. When one examines the dates of Ms. Wofford's entrance and exit from Parkside, it is apparent that the hospital held her for only one day past the mandatory 3 days stipulated in the consent form she signed. Nevertheless, a lawsuit for false imprisonment was filed and ultimately won by Mrs.Wofford. Due to procedural problems involving the various judges who heard the 5-year long case, the verdict was later overturned on appeals. However, at the conclusion of the appeals trial, and after the jury was discharged, one of the Supreme Court judges hearing the case made the following statement to the assembled plaintiff and defendants:

> I think that what you did to this woman was absolutely outrageous and a disgrace to your system and a disgrace to my system. This hospital had no authority to keep this woman, mentally ill or not, without following court procedures, good intentions or not. And I think that's outrageous. And I hope you know, I certainly respect this jury's verdict, but I hope, because you walk out of here Scott Free, that you don't take that as a license to continue to falsely imprison people like Mrs. Wofford. I am absolutely appalled. And, again, I have some faith that you will do whatever you need to do to straighten that out (pg 2).

Anecdotal Observations

As a former Intake Coordinator, the author of this research has worked extensively with the mentally ill in two inpatient facilities. For 2 years, she took part in the process of civilly committing adult mental health patients to treatment. In a professional capacity she was responsible for assisting doctors in preparing legal documents for commitment, delivering the notarized documents to court, advising patients of their legal rights, and accompanying them to and observing many of their hearings.

Those professional experiences allowed her to become very familiar with the mental health laws as they exist and are practiced at one mental health facility in one county in the state of Oklahoma. As a result, the opinion was formed that, although current mental health law was designed to carefully protect the rights of mentally ill individuals, the letter of the law and its practice do not coincide in such a way as to fulfill the purpose and intent of the law. Anecdotal observations point to several deficiencies with regards to how the rights of the mentally ill were carried out. Most notably they included:

1. Examination of the mentally ill was often carried out by only one licensed mental health professional, instead of the two dictated by law. The second physician signing the emergency detention paperwork rarely ever saw the patient.
2. Examinations were often completed by medical residents who had not yet completed their psychiatric rotations.
3. Sections of the legal, notarized paperwork were often filled in by those other than licensed mental health professionals. Often sections were left blank and/or did not give the information requested by the court.

4. Judges appeared to trust that the examinations of the mentally ill and the attendant paperwork had been completed as mandated by law, and made decisions based on those assumptions.
5. When patients did not appear to meet the criteria of dangerousness to self or others, or as being unable to care for their own basic needs, judges often ordered involuntary commitment anyway.
6. When patients' presentations were contrary to what the physician's statement outlined, the statement was generally considered more relevant.
7. The adversarial process dictated by law was not present in the involuntary commitment hearings.
8. The mentally ill were often not informed of their rights by the public defender or the court, and a member of the family was never notified, as specified by law.

Such observations led to the authors interest in the rights of the mentally ill, the process of civil commitment, and the part judges play in insuring that the process is carried out fairly and as mandated by law. The study at hand followed as a consequence, and produced the following hypotheses: 1) Less than 50% of ABA and AALS accredited law schools would offer training in mental health law and abnormal psychology; 2) Those who did offer training in these two areas would do so on an elective basis and; 3) There would be a need for recommendations regarding judicial preparation for conducting involuntary commitment hearings.

CHAPTER III

METHOD

Participants and Procedures

Because judges are central to the process of involuntarily committing their citizenry, and because they are specifically tasked with ultimately ensuring that the constitutional and statutory rights of those who fall under their jurisdiction are protected, their educational preparation for involuntary commitment hearings is very salient. Because their judgments should be based on the strict statutes of mental health law as well as a fundamental understanding of abnormal psychology, their preparation to ultimately integrate the same was seen as important.

One-hundred-eighty-five research packets were mailed to the Deans of Academic Affairs at all ABA (American Bar Association) and AALS (American Association of Law Schools) accredited law schools in the United States and U.S. Territories. Their names and addresses were secured from the ABA and AALS. The research packets included a cover letter, the 2-page survey instrument and a postage-paid envelope to return their responses. A second mailing went out approximately 6-weeks after the first mailing and included the research packet and a reminder letter. The study was conducted during the Fall of 2000 under the auspices of the University of Oklahoma, Educational Psychology Department. The cover letter and survey questions used in this study are included at the end of this paper.

Instruments

The research instrument covered institutional variables such as public or private status; the number of students enrolled in the university and in the law program; the type(s) of degree(s) offered; the number of full and part-time faculty; information related to coursework, seminars, clinical practica or any training related to mental health law and abnormal psychology; the actual courses offered; the training emphasis on types of law; the importance placed by the institution on training in mental health law and abnormal psychology; specifics that are covered in any coursework offered in the areas of mental health law and abnormal psychology; the Deans' opinions as to whether judges should continue to make involuntary commitment decisions; and a comments section.

Specifically, the questions covered on the instrument centered on whether the law school offers coursework, seminars, clinical practica, or any relevant training in the areas of abnormal psychology and mental health law. The deans were asked to include the titles of any courses available in these areas. The deans were also asked to rate, on a 6-point Likert scale) the importance they place on training in abnormal psychology and mental health law. Lastly, the deans were given checklists of topics specific to basic instruction in abnormal psychology and mental health law. They were asked to check those topics covered in any of the instruction offered in the two target areas.

Data Analysis

SPSS (Statistical Package for the Social Sciences) was used to analyze the data. Analyses for this exploratory study were largely descriptive statistics used to describe the current state of judicial training in the areas of mental health law and abnormal psychology. Correlations were run on institutional variables and the number of courses

offered in mental health law and abnormal psychology, as well as on institutional variables and the importance placed on training in these areas by the law schools. T-tests were run to determine if there were any significant differences between public and private law schools and the number of courses they offer in mental health law and abnormal psychology; to determine if there were any significant differences between the number of courses offered by institutions that offer only the J.D. and those that offer the J.D. and other degrees; and to determine if there were any significant differences between public and private institutions regarding the importance they place on training in mental health law and abnormal psychology.

CHAPTER IV

RESULTS

Of the 185 research packets mailed, a total of 109 Deans of Academic Affairs responded with completed surveys. The total number of ABA and AALS schools included in the study was reduced to 184 after the Department of the Navy's Judge Advocate General's office wrote to say that involuntary commitment does not come under their purview in the Armed Forces. Thus, the response rate to this survey was 59%.

The sample in this study was ultimately comprised of more deans from private law schools (62) than deans from public law schools (47). The majority of the schools offered only a J.D. (Juris Doctorate) (70), with the remaining offering the J.D. as well as other related law degrees. The average number of full-time faculty was 37, and ranged from 15-101. The average number of part-time faculty was 42, ranging from 0-250. The average school size was between 10,000 and 17,000 students, and ranged from under 5,000 to 80,000 or greater. The average size of the actual law school in the surveyed institutions was 685, and ranged from 140 to 1,800 students.

The results of this study can be best explained in descriptive statistics that point to the frequencies and measures of central tendency associated with the data. Nevertheless, correlations and t-tests were also run to further explain the results. Unfortunately, due to a general lack of correlated variables, the data did not lend itself to regression analysis. Indeed, even though many of the variables were dichotomous, and could have been

submitted to a logistic regression, the correlations were not present to support that type of analysis.

Correlations were run on the number of courses offered in mental health law or abnormal psychology, the number of students enrolled in the institution and in the law school, the number of full and part-time faculty, and the importance placed by the Deans on training in mental health law and abnormal psychology. Table 1 shows the resulting correlation matrix.

Correlational Analyses

Table 1.
Correlations of Institutional Variables and Emphasis Placed on Training

		COURSES	NUMINSTI	NUMSTUD	FULLFAC	PARTFAC	IMPMHL	IMPABPSY
COURSES	Pearson	1.000	.057	.126	.167	.110	**.386	.171
	Sig.	.	.559	.206	.085	.272	.000	.102
	N	109	106	103	107	101	98	93
NUMINSTI	Pearson	.057	1.000	.009	.125	-.141	.062	.023
	Sig.	.559	.	.929	.208	.167	.551	.827
	N	106	106	100	104	98	95	90
NUMSTUD	Pearson	.126	.009	1.000	**.797	**.727	.058	-.051
	Sig.	.206	.929	.	.000	.000	.579	.635
	N	103	100	103	101	96	94	90
FULLFAC	Pearson	.167	.125	**.797	1.000	**.626	.023	.091
	Sig.	.085	.208	.000	.	.000	.824	.391
	N	107	104	101	107	101	96	91
PARTFAC	Pearson	.110	-.141	**.727	**.626	1.000	.070	-.079
	Sig.	.272	.167	.000	.000	.	.510	.472
	N	101	98	96	101	101	91	86
IMPMHL	Pearson	**.386	.062	.058	.023	.070	1.000	**.614
	Sig.	.000	.551	.579	.824	.510	.	.000
	N	98	95	94	96	91	98	93
IMPABPSY	Pearson	.171	.023	-.051	.091	-.079	**.614	1.000
	Sig.	.102	.827	.635	.391	.472	.000	.
	N	93	90	90	91	86	93	93

** Correlation is significant at the 0.01 level (2-tailed).

COURSES = # of courses offered in mental health law and/or abnormal psychology
NUMINSTI = # of students enrolled in the institution
NUMSTUD = # of students enrolled in the law school
FULLFAC/PARTFAC = # of full and part-time faculty at the institution
IMPMHL/IMPABPSY = importance placed on training in mental health law and abnormal psychology

As the above table shows, the only significant correlations (other than number of full and part-time faculty) were found in the self-evident positive relationship between the number of courses offered in mental health law/abnormal psychology and the emphasis placed on training in mental health law, as well as in the positive relationship between the importance of training in mental health law and the importance of training in abnormal psychology.

t-Tests

Three independent samples t-tests were run on the data. The first t-test looked for significant differences between public and private institutions and the number of courses in mental health law and/or abnormal psychology offered. No significant differences were found. The same outcome resulted from the second t-test, which looked for significant differences between institutions that offered only a J.D. and institutions that offered a J.D. as well as other degrees. The third t-test looked for significant differences between public and private institutions and the importance each placed on training in mental health law, and the importance each placed on training in abnormal psychology. Again, there were no significant differences.

Descriptive Statistics

As noted above, the data gleaned from this study lends itself primarily to descriptive statistics. Indeed, the descriptive statistics run on the data yielded much in the way of information about law schools and the preparation they offer future judges with regard to training in mental health law and abnormal psychology.

Table 2 delineates the institutional variables, measures of central tendency, and frequencies of responses. Variables include the public or private designation of the

institution; the type of degree offered at the institution (J.D. only, or J.D. and other degrees); the numbers of full and part-time faculty; the size of the total student population; and the size of the law school population.

Table 2.
Measures of Central Tendency and Frequencies for Institutional Variables

Variable	Mean	Median	Mode	Range	% Frequency
Public Institution	-	-	-	-	43 (47)
Private Institution	-	-	-	-	57 (62)
J.D. Degree Only	-	-	-	-	64 (70)
J.D. & Other	-	-	-	-	36 (39)
Fulltime Faculty	37	35	30	15-101	- -
Part-time Faculty	42	30	30	0-250	- -
School Size	10,000-15,000	10,000-15,000	under 5,000	under 5,000-80,000 or >	- -
Law School Size	685	650	650	140-1,800	- -

With regard to the deans' responses about offering any practica, seminars or coursework in mental health law, 65% (71) of the deans indicated that they offered some training, and 35% (38) indicated that they offered none (N = 109). Only 106 deans responded to the question of whether they offered practica, seminars or coursework in abnormal psychology, with 14% (15) indicating yes, and 85% (91) indicating no. The mean of actual coursework for mental health law and abnormal psychology was 1 course, with the number of courses ranging from of 0-6. Forty percent (44) of the deans indicated that they offer no coursework in mental health law or abnormal psychology, 43% (47) indicated that they offer 1 or 2 courses, 15% (17) indicated that they offer 3 or 4 courses, and 1% (1) indicated that they offer 6 courses (total N = 109).

Tables 3 and 4 summarize the data with regard to the *importance* the responding deans indicated that they place on training in mental health law and abnormal psychology.

Table 3.
Importance the Law School Places on Training in Mental Health Law

Response	Frequency	Percent	Valid %	Cumulative %
Extremely Unimportant	4	3.7	4.1	4.1
Quite Unimportant	17	15.6	17.3	21.4
Somewhat Unimportant	21	19.3	21.4	42.9
Somewhat Important	49	45.0	50.0	92.9
Quite Important	7	6.4	7.1	100.00
N	98	89.9	100.0	
Missing	11	10.1		

Table 4.
Importance the Law School Places on Training in Abnormal Psychology

Response	Frequency	Percent	Valid %	Cumulative %
Extremely Unimportant	19	17.4	20.4	20.4
Quite Unimportant	24	22.0	25.8	46.2
Somewhat Unimportant	28	25.7	30.1	76.3
Somewhat Important	21	19.3	22.6	98.9
Quite Important	1	.9	1.1	100.0
N	93	85.3	100.0	
Missing	11	14.7		

Tables 5 and 6 outline the specifics covered in the responding law schools' coursework, seminars or practica regarding mental health law and abnormal psychology. Each presents a breakdown of many of the fundamentals essential to basic knowledge in these two areas. Tables 5 and 6 outline how many law schools offer training in these areas.

Table 5.
Specifics Covered in the Instruction of Mental Health Law

Topic	# of law schools offering specific training in mental health law
1. Mental health law of their state	37
2. General overview of mental health law	55
3. Dangerousness to self	49
4. Dangerousness to others	49
5. Unable to care for self due to mental illness	39
6. Emergency detention	45
7. Involuntary commitment	54
8. Adversarial representation of the mentally ill	43
9. Court commitment paperwork	19
10.Decision-making process for commitment	42
11.Least restrictive treatment	43
12.Rights of the mentally ill	54
13.Parens patriae	37
14.Other	12

With regard to the deans' beliefs about whether involuntary commitment decisions should continue to be made by judges, only 71 deans responded to this particular question. In nearly every case, the deans believed that involuntary commitment decisions should continue to be made by judges. One dean wrote that, yes, involuntary commitment decisions should continue to be made by judges, but that they should be "in consultation with health care professionals." Another judge wrote "Maybe—[it's a] complicated issue and judges may be [the] best of not so great alternatives." Only one (1%) of the responding deans indicated that judges should *not* continue to make involuntary commitment decisions. Many of the deans left this question unanswered. Of the few who

did not indicate yes or leave the question blank, they wrote, "I don't know" and "No opinion."

Table 6.
Specifics Covered in the Instruction of Abnormal Psychology

Topic	# of law schools offering specific training in abnormal psychology
1. DSM-IV	8
2. Mental Retardation/Developmental Disorders	6
3. Cognitive Disorders	7
4. Mental Disorders Due to a Medical Condition	4
5. Substance-Related Disorders	5
6. Schizophrenia/Psychotic Disorders	7
7. Mood Disorders	6
8. Somatoform Disorders	1
9. Impulse-Control Disorders	2
10.Personality Disorders	7
11.Sexual/Gender Identity Disorders	4
12.Dissociative Disorders	2
13.Eating Disorders	1
14.Anxiety Disorders	1
15.Factitious Disorders	1
16.Adjustment Disorders	1
17.Psychopharmacology	4
18.Assessment Methods	5
19.Sleep Disorders	1
20.Treatment Modalities	5

Nevertheless, those deans that offered comments provided another perspective about the preparation judges have for carrying out fair and legally sound involuntary commitment hearings. Their comments included:

"There should be more [attorneys trained in mental health law and abnormal psychology]."

"I wish that we exposed students to more in this area. At present a psychiatrist makes one to two presentations per semester to students in the clinic."

"We ought to do more. We offer almost none."

"We do not offer these two courses. If the student wishes, the Vice Chancellor will allow our law students to take a graduate course on [another] campus if it will help with the student's future."

"[I] think more [education] would be useful."

"This area is important, but we only cover it through other classes: criminal, estates and trusts, elder law, etc."

"Cross-disciplinary training and education of law students is essential. Direct exposure to mental health consumers has provided, in the words of one student, 'the best experience I've had in law school.' Clinical training in mental health law should be encouraged."

"We do not have any course that deals directly and explicitly with abnormal psychology. Aspects of abnormal psychology are addressed in other courses, including mental health law and criminal law...."

"Our failure to take seriously mental disability law as a law school subject is shameful. [I] believe that it is, in large part, due to the way we—law schools and the rest of society—utterly trivialize persons with mental disabilities and their legal status."

"Woefully inadequate."

CHAPTER V

DISCUSSION

Hypotheses and Research Questions

Overall, the information gleaned from this study provides an interesting and informative look at the preparatory coursework and training future mental health judges receive in the areas of mental health law and abnormal psychology. Further, the responses from the Deans of Academic Affairs from 109 ABA and AALS accredited law schools offer a unique look into the importance law school administrators place on training in mental health law and abnormal psychology.

Three hypotheses served as a foundation to this research. Namely, that less than 50% of ABA and AALS accredited law schools would offer training in mental health law and abnormal psychology; that those who did offer training in these two areas, would do so on an elective basis; and that there would be a need for recommendations regarding judicial preparation for conducting involuntary commitment hearings.

The first hypothesis was not borne out in one aspect of this study. Indeed, of the 109 responding law schools, 65% of the deans of academic affairs indicated that they offer *some form* (seminars, practica, or coursework) of training in mental health law, well over the 50% mark set by the researcher. However, of the 106 deans who responded to the question as to whether they offer any training in abnormal psychology only 14% answered in the affirmative, generously confirming that portion of the research hypothesis. Further, it should be noted that when the deans were asked to specify the

number of actual *courses* (not practica or seminars), the mean number of courses offered was 1, with 1 also being the median, and 0 being the mode. The total number of courses offered ranged from 0-6. Indeed, 40% (44) of the 109 responding law schools offer no coursework in mental health law and abnormal psychology. Another 43% (47) offer only 1-2 courses, and 15% and 1% offer 3-4 and 6 courses respectively. And lastly, of those law schools offering some form of training (seminars, practica or coursework) only 2% (2) *required* coursework in mental health law or abnormal psychology. The majority of the responding deans indicated that such training would be *elective*. Such outcomes tend to support the hypothesis that training in these areas is not a priority. Further, the results call into question how adequately prepared judges are to make involuntary commitment decisions.

Other results point to similar conclusions and questions. With the responding deans indicating that the importance placed on training in mental health law (39% extremely *unimportant* to somewhat *unimportant*) and abnormal psychology (65% extremely *unimportant* to somewhat *unimportant*) one can easily come to the conclusion that training in this area, even when offered, may be cursory or only minimally stressed. Indeed, only 6% and 1% of the deans noted that that training in mental health law and abnormal psychology respectively is quite important.

Given that individuals facing involuntary commitment will be deprived of their freedom, and may even be forced to take psychotropic medications, or submit to treatments such as ECT, such results are disappointing, if not frightening.

One would hope that the individuals tasked with such potentially life-altering decisions would be well-prepared to carry out such sensitive responsibilities. But as the

results of this study show, not only are judges not educationally prepared on a basic and fundamental level to make involuntary commitment decisions, they are often even less prepared when the education pertains to the specifics of understanding the mentally ill and the laws that pertain to their presence in a courtroom (see Tables 6 and 7).

Indeed, of those deans of academic affairs who indicated that they offer some form of training (practica, seminars or coursework) in mental health law, 70 indicated that they do not cover in their instruction the mental health law of their own state. The numbers for those schools offering some form of training in abnormal psychology were even less encouraging. Indeed, of the 108 who responded to the questions regarding specifics covered in their instruction, only 6 covered mood disorders in their instruction, and only 5 covered schizophrenia and psychotic disorders, two of the most common reasons for involuntarily committing mentally ill individuals.

Once again, the question must be asked—without training in mental health law, how can judges implement its statutory requirements? Without training in abnormal psychology, how can judges recognize when individuals meet the strict criteria for civil commitment of dangerousness to self or others, or of an inability to care for their basic needs as a function of their mental illness? Certainly the distinction between a person with delusions of grandeur who thinks he should be president of the United States, and a person with persecutory delusions who believes the president of is after him and so must be assassinated, could make the difference between meeting or not meeting the statutory requirements of dangerousness.

If, however, judges are not trained to distinguish between unusual, even abnormal—but not dangerous-- behavior, and behavior that portends danger, they may be likely to

take away a person's freedom, and thereby force treatment, based simply on the oddity of the person's behavior, and not on their potential for dangerousness to self or others. That type of "common-sense" application of the law (that abnormal behavior should be treated) is directly counter to the reforms that have been applied to mental health statutes specifically to protect the rights of the mentally ill.

The foregoing results point in the direction of judges who have not received the educational preparation that would be consistent with an adequate foundation for making involuntary commitment decisions. Even so, of the 71 deans who responded to the question, "*Do you believe that involuntary commitment decisions should continue to be made by judges?,*" 70 (64%) answered yes. There was only one dissenting vote (1%).

A look at the training judges receive in mental health law and abnormal psychology becomes well-targeted when considering the consequences of the decisions they make regarding the lives of mentally ill individuals. As part of her work in the field of mental health, the author has witnessed some disturbing incidents involving the involuntary commitment process.

In one instance, she visited with an attorney who had been assigned to represent an indigent patient facing commitment, and who had requested a jury trial, instead of the customary hearing—a right which is stipulated by mental health law. This particular attorney was covering commitment cases for one particular county while the attorney who normally represented indigent clients was on vacation. During the course of a conversation with the author she said, "I've never even read the mental health law. I'm just covering for the attorney who's on vacation. I don't know what to do for a person wanting a jury trial." Further, this particular attorney did not even know where to find a

copy of the law. The author faxed her a copy, for which she was very grateful. Nevertheless, such a lack of knowledge (and or unwillingness to search it out) speaks directly to what may be considered a lack of judicial concern for those individuals facing the potential loss of their freedom as well as possibly forced treatment—medicinally or otherwise.

On another occasion, the author came in contact with a doctor (who regularly petitioned judges to involuntarily commit his patients) who made the comment while referring to a patient, "He's EOD'd (Emergency Order of Detention). We can do anything we want to him."

And in one especially disturbing case, a compliant, non-violent, mentally ill, elderly woman was taken away in shackles to a state hospital. As she cried, "What did I do?" bystanders asked if the police officers could transport her without shackles. Following their understanding of the law, the officers said, "We have to [keep her in shackles]. She's a mental patient." Such instances, albeit anecdotal, call into question whether the rights of the mentally ill are being protected, and whether judges could be better prepared to insure the same. Only further research can shed light on how pervasive the problem may be, or whether certain instances represent the insensitivity of only a few.

Several weaknesses impact the generalizability of this study. First, a 59% response rate is lower than one would prefer in a survey study. Second, some of the deans surveyed failed to answer certain questions, lowering the response rate for those particular items. Lastly, instructors may emphasize mental health law and or abnormal psychology issues in their courses without the deans of academic affairs being totally aware of this contingency. Nevertheless, if, as this study suggests, judges are not

adequately prepared educationally to recognize mental illness and apply the statutory laws mandated for involuntary commitment, certain recommendations emerge.

Recommendations for Training

Any recommendations that present as a function of the foregoing research must be balanced against the practical and economic realities attendant to training and practice. As such, one must consider several key issues. First, how many lawyers and judges actually practice mental health law in the United States? Second, how economically feasible is it to train all future attorneys in abnormal psychology and mental health law, when the bulk of them will likely not practice that subspecialty? And third, are there ways to offer the appropriate training in abnormal psychology and mental health law to only those lawyers and judges who will actually participate in civil commitment (or other applicable) hearings. Given these caveats, the following recommendations are set forth.

First, law schools could offer specific training (possibly in the form of a seminar open to students of the law school as well as outside individuals) on an annual or biannual basis for lawyers or judges who plan on, or who have accepted assignments to practice mental health law. This training would include the mental health law of the state in which the law school resides. Such training could include a didactic component that clearly spells out the established criteria for the involuntary commitment of the mentally ill. A clear understanding of the legal criteria that a mentally ill person must meet prior to civil commitment would be a major part of this training. At a minimum, what constitutes the criteria for dangerousness to self or others, and what constitutes the criteria for being unable to take care of one's basic needs as a function of their mental illness should receive close attention.

A second area of training that could be offered has to do with the recognition of the signs and symptoms of mental illness. While such training could have potential value to all future attorneys and judges, education in this area could be offered on a seminar basis similar to or included with that described for mental health law. Training in this area could be both didactic and practical. Indeed, law students and practicing attorneys could benefit greatly from the experience of interacting with the mentally ill, especially in a civil commitment capacity. This type of training could include a minimum of 1 multi-component seminar in abnormal psychology that would cover the basic manifestations of severe mental illness, the types of treatment available for those illnesses, and how the legal criteria for commitment coincide with the same. That seminar could offer basic training for future and current judges and attorneys in the use of the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV)—a complete compendium of mental disorders, their signs and symptoms, course and prevalence. Disorders often attendant to civil commitment, such as schizophrenia, personality disorders, and mood disorders should be highlighted.

Limited (1-3 day) practicum experiences could follow, giving future attorneys and judges the opportunity to work with mentally ill clients, and participate in involuntary commitment hearings. Training in this area would offer future attorneys and judges a valuable foundation in mental illness that could be applied to many facets of law and interactions with clients. Further, exposure to the literature on the issues surrounding the training, expertise and practice of a variety of mental health professionals, and exposure to practicing mental health professionals would offer future judges a basic foundation of information with regard to how to effectively work with mental health professionals in

the critical area of civil commitment. Perhaps state and/or national organizations (such as the American Bar Association, American Association of Law Schools, and the American Psychological Association) could collaborate on programs or comprehensive seminars that would benefit the constituents of both the legal and psychological organizations.

Given what we know about therapeutic jurisprudence and its effects on treatment outcome, it is recommended that law schools offer training in this area. Again, such training could be offered as a single seminar, or as part of a larger training effort. Therapeutic jurisprudence has the potential to change the manner in which clients and their mental illness will be approached in that therapeutic jurisprudence proposes that clients be given the opportunity to participate in their hearings, be treated with dignity and respect, and receive judicial mandates in an environment of trust. Indeed, as noted earlier, when clients perceive the *process* of an involuntary commitment hearing as fair, they are more likely to benefit from treatment, whether or not they agree with the outcome of the civil commitment hearing. Training of attorneys in this area would be highly beneficial, and could be applicable to many other areas of legal practice.

Adversarial representation is something about which law students learn as they study how to defend clients. Indeed an adversarial process is the foundation upon which our judicial system is based. That same adversarial representation should be taught to attorneys who represent mentally ill clients in their involuntary commitment hearings. To do any less is to somehow relegate the mentally ill to a position subordinate to those accused of crimes. To receive no training in adversarial representation for mentally ill clients would seem to make a tacit statement that mentally ill clients as well as their rights and freedom are not important enough to warrant such representation. Once again,

a component addressing adversarial representation could be included in a broad training seminar.

Lastly, the decision-making process attendant to the involuntary commitment process should be explored with future and current attorneys and judges who work with or have plans to work with the mentally ill. A critical evaluation of how we perceive the mentally ill and their need for treatment is a crucial component of understanding the mentally ill and appropriately applying laws that govern their freedom and imposed treatment. A decision-making process that is congruent with the laws that govern civil commitment should be taught so that a parens patriae or common sense approach is not arbitrarily used by default.

Truly, treatment of the mentally ill has dramatically improved since the days of spinning cages, and the chaining of people to beds stained with excrement. Statutory mandates now offer legal protection to those found to be mentally unsound. No longer can individuals be civilly committed without the due process afforded by law. Empirically validated treatments now exist for the treatment of many mental disorders. Even so, many of our mentally ill may not meet the criteria by which that treatment comes to be mandated. Indeed, the weighty decision to take away an individual's freedom as a function of their mental illness, and possibly force treatment for the same, dictates that we must be sure that we are abiding by the laws that have been designed to protect the rights of those who are victims of mental illnesses.

While many professionals may be involved in the process of civilly committing a mentally ill individual, mental health judges and defending attorneys are tasked with carrying out the judicial end of that process—that is insuring that the laws are followed.

Indeed, such was the point of years of reforms that demanded that the law intercede in such a sensitive matter. Judges in particular have the responsibility to insure that mentally ill persons brought before the court are given due process. They have the duty to insure that the rights of the mentally ill are protected insofar as involuntary commitment and treatment are concerned.

This study, however, suggests that those tasked with judicial oversight in this area, may not have the training or education necessary for the reasonable application of psychological knowledge and mental health law in hearings designed to determine who meets the strict criteria for involuntary commitment and forced treatment. Training in those crucial areas could mediate this problem. By requiring fundamental training (via seminars or workshops) in mental health law and abnormal psychology for those who will practice or currently practice mental health law, law schools (possibly in concert with legal and psychological associations) will be in a better position to insure that future judges and attorneys are adequately prepared to recognize mental illness and appropriately determine whether those so afflicted meet the statutory requirements that could result in civil commitment and forced treatment. Further, by providing such training for attorneys and judges currently practicing mental health law, they would be offering a valuable community service and contributing to the protection of the rights of individuals who clearly need such protection.

Areas for Future Research

As with most research, this study answered several questions. It also raised many other questions appropriate for continued investigation in the area of judicial training. The following questions could be well-targeted as the areas of training in mental health

law and abnormal psychology are researched. Just how many attorneys and judges currently practice mental health law in the United States. What are the various capacities in which mental health law is practiced (i.e. involuntary commitment hearings, competency hearings, etc.)? What does the legal profession's ethical code say about practicing any subset of law without specific training in that area? What is the general scope of licensure with regard to practicing law and demonstrating competence in any subspecialty? What do the syllabi of law school courses reveal in the way of topics applicable to abnormal psychology and mental health law?

Is mental health law covered on the bar exam? Does the American Bar Association currently offer any continuing education with respect to subjects relevant to mental health law? Do American Bar Association and American Association of Law Schools accredited schools require any prerequisite undergraduate work in abnormal psychology? What do mental health professionals, mental health consumers, the general public, and practicing attorneys and judges have to say about the potential need for training in abnormal psychology and mental health law for attorneys and judges practicing mental health law? The answers to these and other relevant questions have the potential to further refine and improve upon the reforms that have so dramatically improved how we treat the mentally ill in the United States.

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APPENDIX

MATERIAL USED WITH PARTICIPANTS

The University of Oklahoma

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

October 1, 2000

Dear Dean of Academic Affairs,

My colleagues and I are conducting a study about the training provided at American Bar Association (ABA) and American Association of Law Schools (AALS) accredited training programs with regard to mental health law and abnormal psychology. Specifically, we are interested in the types and amount of training students receive in these two areas.

Your name was selected from a list of APA and AALS accredited law schools, as we are attempting to contact the Deans of Academic Affairs of all accredited law schools. We would appreciate it if you would take only a few minutes of your time to participate in our short research project. The survey should take no longer than 10 minutes to complete. A stamped and return-addressed envelope has been provided for you to return you answers to us.

We hope that the results of this investigation will provide information to assist us in understanding the training future attorneys and judges may receive in the areas of mental health law and abnormal psychology. As with any research, your participation is voluntary, and your responses will be kept confidential. Please do not put your name on the questionnaire. At no time will your answers appear with your name, or the name of your institution. Indeed, your responses will be totally anonymous. No direct risks or benefits are associated with participation in this research.

Thank you for taking the time to assist us with our research. If you have any questions about this research, or would like a copy of the results, please contact Gail Poyner at (405) 391-4062 or at gpoyner@okcity.tds.net. This research study has been approved by the Institutional Review Board in the Office of Research and Administration at the University of Oklahoma. Should you have any questions about your rights as a research participant, you may call the Office of Research Administration at (405) 325-4757.

The information you provide us will contribute to a better understanding of an important interface between attorneys and judges and the topic of mental illness and mental health law. We recognize that the demands on your time are many, and therefore your participation is greatly appreciated.

Respectfully,

Gail Poyner, M.Ed.
Principal Investigator
Doctoral Student, University of Oklahoma

Dr. Terry Pace
Co-Investigator/Advisor/Associate Professor
University of Oklahoma

820 Van Vleet Oval, Room 321, Norman, Oklahoma 73019-2041 PHONE: (405) 325-5974 FAX: (405) 325-6655

Accredited Law Schools
Training in Mental Health Law and Abnormal Psychology

Part I: To be completed by the Secretary to the Dean of Academic Affairs
Part I: Institution/Program Information

1. My institution is ☐ Public ☐ Private

2. The graduate degree my program offers is ☐ J.D. ☐ Other _____
(Please Specify)

3. Approximately how many faculty members does your *program* (law school) employ?

Full-time faculty _____ Part-time or adjunct faculty _____

4. Approximately how many students are enrolled in your *institution* (not just in your program)?

☐	Under 5,000		
☐	5,000 to 9,999	☐	45,000 to 49,999
☐	10,000 to 14,999	☐	50,000 to 54,999
☐	15,000 to 19,999	☐	55,000 to 59,999
☐	20,000 to 24,999	☐	60,000 to 64,999
☐	25,000 to 29,999	☐	65,000 to 69,999
☐	30,000 to 34,999	☐	70,000 to 74,999
☐	35,000 to 39,999	☐	75,000 to 79,999
☐	40,000 to 44,999	☐	80,000 or more

5. Approximately how many students are enrolled in your accredited law *program*? _____

6. Does your program provide coursework, seminars, clinical practica or any training related to *mental health law*? ☐ Yes ☐ No
If yes, coursework in mental health law is: ☐ Required ☐ Elective # of credit hours _____
If yes, seminars, practica, or workshops in *mental health law* are: ☐ Required ☐ Elective # of credit hours _____

7. Does your program provide coursework, seminars, clinical practica or any training related to *abnormal psychology*? ☐ Yes ☐ No
If yes, coursework in abnormal psychology is: ☐ Required ☐ Elective # of credit hours _____
If yes, seminars, practica, or workshops in *abnormal psychology* are: ☐ Required ☐ Elective # of credit hours _____

8. Please list any courses you offer in *mental health law* and/or *abnormal psychology*

_____ _____

_____ _____

_____ _____

_____ _____

Please give the following page to the Dean of Academic Affairs for completion. Thank You!

Part II: Training Information

1. Please rank from 1-8 the training emphasis your program places on the following types of law: (1 = most emphasis; 8 = least emphasis)

Civil	_____	Tax	_____
Criminal	_____	Trial	_____
Business	_____	Mental Health	_____
Corporate	_____	Other (please specify)	_____ _____

2. Please indicate the importance you place on training in *mental health law*:

1	2	3	4	5	6
extremely unimportant	quite unimportant	somewhat unimportant	somewhat important	quite important	extremely important

3. Please indicate the importance you place on training in *abnormal psychology*:

1	2	3	4	5	6
extremely unimportant	quite unimportant	somewhat unimportant	somewhat important	quite important	extremely important

4. Please check any specifics that are covered in your instruction of *mental health law*:

- ☐ The mental health law of the state in which you reside
- ☐ General overview of mental health law
- ☐ Dangerousness to self
- ☐ Dangerousness to others
- ☐ Inability to care for basic needs due to a mental illness
- ☐ Emergency Detention
- ☐ Involuntary Commitment
- ☐ Adversarial representation of mentally ill client facing involuntary commitment
- ☐ Court commitment paperwork
- ☐ Decision-making process for court commitment
- ☐ Least restrictive treatment
- ☐ Rights of the mentally ill
- ☐ Parens Patriae approach to civil commitment
- ☐ Other (please specify) _____

5. Please check any specifics that are covered in your instruction of *abnormal psychology*:

- ☐ Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV)
- ☐ Mental Retardation/Developmental Disorders
- ☐ Cognitive Disorders—delirium, dementia, amnestic, etc.
- ☐ Mental Disorders due to medical conditions
- ☐ Substance-related disorders
- ☐ Schizophrenia and other psychotic disorders
- ☐ Mood Disorders
- ☐ Somatoform Disorders
- ☐ Impulse-Control Disorders
- ☐ Personality Disorders
- ☐ Sexual/Gender Identity Disorders
- ☐ Dissociative Disorders
- ☐ Eating Disorders
- ☐ Anxiety Disorders
- ☐ Factitious Disorders
- ☐ Adjustment Disorders
- ☐ Psychopharmacology
- ☐ Assessment Methods
- ☐ Sleep Disorders
- ☐ Treatment Modalities

6. Do you believe that *involuntary commitment* decisions should continue to be made by judges?
☐ Yes ☐ No If No, by whom should these decisions be made? _____

7. Do you have any comments about the training of attorneys in the areas of *mental health law* and/or *abnormal psychology*? ☐ No ☐ Yes (Please write any comments on the reverse side of this page.)

Thank you very much for your participation. Please return this survey in the SASE provided. For results please contact Gail Poyner at 14211 S.E. 44th St., Choctaw, OK 73020 405-3914062 gpoyner@okcity.tds.net

October 30, 2000

Dear Dean of Academic Affairs,

A few weeks ago I mailed you the enclosed survey, which is part of a research study being conducted at all ABA and AALS accredited law schools. If you have already returned the survey, please accept my thanks for your participation. There is no need to fill out a second response.

If you have not returned the survey you received in September, I hope will take just a few minutes to complete the enclosed one. Your input is greatly needed to gain a true picture of the research being conducted.

Thank you again for your participation. It is very much appreciated.

Respectfully,

Gail A. Poyner
Doctoral Student

INSTITUTIONAL REVIEW BOARD APPLICATION
FOR APPROVAL OF THE USE OF HUMAN SUBJECTS IN AN INVESTIGATION CONDUCTED ON THE NORMAN CAMPUS AND/OR BY UNIVERSITY OF OKLAHOMA FACULTY, STAFF OR STUDENTS

Your application for approval of the use of human subjects should consist of eleven (11) copies* of three parts:

PART I - A COMPLETED APPLICATION FORM
PART II - A DESCRIPTION OF YOUR RESEARCH STUDY
PART III - SUBJECT'S INFORMED CONSENT FORM FOR PARTICIPATION IN YOUR STUDY

You should attach supplementary information pertinent to this study that will help the board members in their review of your application, i.e., questionnaires, test instruments, letters of approval from cooperating institutions or/and organizations. Failure to submit these items will only delay your review.

Applications are due not later than the 1st day of the month in which you wish the proposed project reviewed

Please return completed proposals to:

Campus Mail:
Office of Research Administration
Buchanan Hall, Room 314

U.S. Mail:
Office of Research Administration
1000 Asp Avenue, Room 314
Norman, Oklahoma 73019-0430

Please call the ORA at 325-4757 and ask for the IRB if you have any questions. Please type your responses.

PART I - APPLICATION FORM

1. **Principal Investigator:**
Name Gail Poyner
Department Educational Psychology
Campus Phone No. 325-2914 E-mail Address gpoyner@okcity.tds.net

If you are a student, provide the following information:
Daytime Phone No. 405-391-4062
Mailing Address 14211 S.E. 44th Choctaw, OK 73020

Faculty Sponsor: Dr. Terry Pace

Department Educational Psychology Sponsor's Phone No. 325-2914

Co-Principal Investigator(s) (Please include name, department, and campus phone number)
None

Signatures:
Principal Investigator Gail A. Poyner
Co-Principal Investigator(s) N/A
Faculty Sponsor (if student research project)

1 - http://research.ou.edu/Forms/IRBForm2000.doc

.. you believe your use of human subjects would be considered exempt from review or qualifies for expedited review as defined in Sections 4 and 12 of the University of Oklahoma Norman Campus Policy and Procedures for the Protection of Human Subjects in Research Activities, you may submit two (2) copies of this application for initial review. If full Board review is required, you will be required to submit nine (9) additional copies.

2. Project Title: An Exploration of American Bar Association and American Association of Law Schools Accredited Training Programs in the Areas of Mental Health Law and Abnormal Psychology

3. Project Time Period: From October, 20000 to June 2001

4. Previous Institutional Review Board-Norman Campus Approval for this project?
Yes ____ No X
If yes, please give date of the action

5. Are you requesting funding support for this project?
Yes ____ No _X
If yes, please give sponsor's name

6. Description of Human Subjects:
Age Range 25-90 Gender (please check one): ___Males; ___Females; Both X
Number of Subjects 181

Special Qualifications
Deans of Academic Affairs at all U.S. accredited law schools

Source of Subjects and Selection Criteria
American Bar Association and American Association of Law Schools

Please check any protected groups included in this study.

___ Pregnant Women	___ Fetuses	___ Children
___ Mentally Disabled	___ Elderly	
___ Mentally Retarded	___ Prisoners	

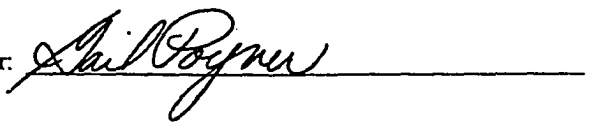
Institutional Review Board Application

Part I : Application Form

1. Principal Investigator:

Gail A. Poyner, M.Ed.
Department of Educational Psychology
Room 321, 820 Van Vleet Oval
University of Oklahoma
Norman, OK 73019-2041
Phone: (H): 405-391-4062; (E-mail): gpoyner@okcity.tds.net

Signature:

Principal Investigator: 

2. Project Title:

An Exploration of American Bar Association and American Association of Law Schools Accredited Training Programs in the Areas of Mental Health Law and Abnormal Psychology

3. Project Time Period:

Academic year 2000-2001. Mailing of research packets to potential participants is scheduled for the first week of October, 2000. Reminder letters and a second packet, if needed, may take place following the initial mail-out.

4. Previous IRB-Norman Campus Approval:

Yes

5. Are you requesting funding for this project?

No

6. Description of human subjects:

Participants will be Deans of Academic Affairs of all American Bar Association and American Association of Law Schools Accredited Training Programs. Approximately 200 Deans of Academic Affairs will receive research materials by mail for their voluntary completion. A minimum of 100 participants is desired.

7. Source of subjects and selection criteria:

All Deans of Academic Affairs of accredited law schools will be mailed research packets. A mailing list will be obtained from the American Bar Association and the American Association for Law Schools. Other than identification as a Dean of Academic Affairs of an accredited law school, no selection criteria will be in force.

Part II: Description of the Study

A. Purpose/Objectives:
There is currently very little research available that examines the training attorneys and judges receive in the areas of mental health law and abnormal psychology. Knowledge of these areas is crucial to their role in the emergency detention and involuntary commitment of mental health patients. The purpose of the present study is to survey the Deans of Academic Affairs of all accredited law schools in the United States to determine what percentage of training programs require instruction in mental health law; to determine what percentage of accredited training programs require training in abnormal psychology; to determine how much training is required of future attorneys and judges; to determine what methods are used to train attorneys and judges in recognizing mental illness; to determine what elective coursework is available in the areas of mental health law and/or abnormal psychology; and to determine if any recommendations emerge for strengthening attorney/judge preparation in the area of mental health law and abnormal psychology.

B. Research Protocol:
The attached materials will be mailed to all Deans of Academic Affairs of all accredited law schools in the United States. A complete list of accredited law schools will be obtained from the American Bar Association and the American Association of Law Schools. The survey questions are designed to be answered easily, and will take approximately 10 minutes or less to answer. Stamped, addressed return envelopes will be provided in the research packets, as will a cover letter introducing the study. An enticement (attached) will be included for the secretaries to the Deans, as they will be asked to complete the demographic portion of the study, and then forward the second half of the instrument to the Deans. A follow up mailing may take place after the initial mailout.

C. Confidentiality:
Participants will be instructed to not put their names on any of the research instruments, and will be assured of the confidentiality of their responses. In no place will the respondents' names appear with their responses, nor will there be any attempt to track responses by name or institution.

D. Subject Benefit/Risk:
No direct benefits to participants are provided as part of this research. Participants will be made aware of all human subjects rights, including the voluntary nature of participation. There is no deception in any of the research procedures. No direct risks have been identified for potential respondents.

The University of Oklahoma

OFFICE OF RESEARCH ADMINISTRATION

September 12, 2000

Ms. Gail A. Poyner
14211 SE 44th
Choctaw OK 73020

Dear Ms. Poyner:

Your research application, "An Exploration of American Bar Association and American Association of Law Schools Accredited Training Programs in the Areas of Mental Health Law and Abnormal Psychology," has been reviewed according to the policies of the Institutional Review Board chaired by Dr. E. Laurette Taylor and found to be exempt from the requirements for full board review. Your project is approved under the regulations of the University of Oklahoma - Norman Campus Policies and Procedures for the Protection of Human Subjects in Research Activities.

Should you wish to deviate from the described protocol, you must notify me and obtain prior approval from the Board for the changes. If the research is to extend beyond 12 months, you must contact this office, in writing, noting any changes or revisions in the protocol and/or informed consent form, and request an extension of this ruling.

If you have any questions, please contact me.

Sincerely yours,

Susan Wyatt Sedwick

Susan Wyatt Sedwick, Ph.D.
Administrative Officer
Institutional Review Board

SWS:pw
FY01-24

cc: Dr. E. Laurette Taylor, Chair, Institutional Review Board
Dr. Terry Pace, Educational Psychology

Student: Gail Poyner
Prospectus Title: *An Exploration of American Bar Association and American Association of Law Schools Accredited Training Programs in the Areas of Mental Health Law and Abnormal Psychology*
Department: Educational Psychology
Program: Counseling Psychology

Prospectus Approved on August 28, 2000 by:

1. _____
Dr. Terry Pace

2. _____
Dr. Cal Stoltenberg

3. Denise Beesley PhD
Dr. Denise Beesley

4. _____
Dr. Jason Osborne

5. Briget C. Murphy-Kelsey
Dr. Briget Murphy-Kelsey

Gail Poyner
Student Signature

PROSPECTUS

Gail Poyner, M.Ed.

Doctoral Student/University of Oklahoma

I. INTRODUCTION

A. Objectives

The objectives of the proposed study are to examine the standard training practices of American Bar Association (ABA) and American Association of Law Schools (AALS) accredited training programs with regard to mental health law and abnormal psychology. The questions this study will seek to answer are: 1) What percentage of ABA/AALS accredited training programs require training in mental health law? 2) What percentage of ABA/AALS accredited training programs require training in abnormal psychology? 3) How much training is required of future attorneys in the areas of mental health law and abnormal psychology? 4) What methods are used to train attorneys in recognizing mental illness? 5) What elective coursework is available in the areas of mental health law and/or abnormal psychology? 6) What recommendations emerge for strengthening attorney/judge preparation in the area of mental health law and abnormal psychology?

B. Background

Historically, mentally impaired individuals have been subject to inhumane legal and "therapeutic" practices. In the 1400's, one could be indefinitely committed to a mental institution with no legal or procedural safeguards. Hilgard (1987) offers a concise look at an era whose appalling treatment of those thought to be mentally ill reminds us of how far we've come. From 1402 until 1930, the Bethlehem Royal Hospital in England was the standard of institutionalization, with similar conditions existing throughout most of Europe. Bedlam

The prison-like atmosphere of the asylums was notably absent from Tuke's retreat, as were the standard medical treatments of purging and bloodletting. The retreat represented an incredible improvement over former conditions.

According to Hilgard (1987), the movement soon spread to the United States and was advanced, in part, by Eli Todd who was a practicing physician and who addressed the Connecticut Medical Society about the work of Pinel. In 1824, the Hartford Retreat was established, with Eli Todd as its medical director. Based on his example, several states soon followed suit and founded publicly supported hospitals for the mentally infirm. Unfortunately, though, many of those were only marginally better than the asylums that had preceded them and many of the mentally ill continued to be housed in jails or other facilities for the needy. It was Dorothea Dix, a Sunday School teacher in Boston, who took notice of the poor treatment of mentally ill patients who were routinely housed with criminals. Over a 40-year period, she succeeded in improving the facilities in several states, building or renovating 30 other state institutions, and influencing the same progress in Europe and Japan.

Each of these reforms, writes Hilgard (1987), contributed to asylums becoming hospitals whose patients had the opportunity to recover and regain their freedom. Many of the patients remained ill but, due to the reforms, they were no longer forced to reside with criminals. And even though the mentally ill continued to be regularly restrained, and no medical modalities existed to treat them, the early 19th century saw the beginnings of humane conditions for some of its neediest individuals. But even with improved living conditions, actual treatment was relatively nonexistent at the time. It was Johann Reil, a German physician, who in 1803 first introduced the notion that mental illness was a psychological phenomenon and should be treated with psychological methods. He advocated that the term "hospital for psychotherapy," replace

"lunatic asylum" when referring to those places designated to treat the mentally ill. He promoted a hospital where the incurable would be made comfortable, be given things to occupy their time, and the treatable to receive therapy with the hope of curing their mental illness.

Hilgard (1987), cites others as having early, yet profound effects on the course of reforming the process whereby the mentally ill received help for their various afflictions. Charcot, Janet, and Freud, among others, further advanced psychotherapy as a treatment for mental illness, which clearly offered vast improvements on earlier methods. Another influential person was Clifford Beers, who was himself a former mentally ill patient, and who, in 1908, wrote *The Mind That Found Itself.* The "Mental Hygiene Movement" was initiated as a result of Beers' personal and forthcoming book. This movement focused on the problems of the mentally ill, as well as increased the awareness of those inclined to acknowledge a heretofore relatively ignored and disenfranchised population. Indeed, the process of reformation had begun, and the early 19th century represented a significant improvement, as compared to its 18th century predecessor, with regard to how the mentally ill were viewed, housed, and treated. Conditions remained far from ideal, but were in stark contrast to earlier times. But however improved conditions were, the fact remained that coerced entrance into the world of institutionalization was relatively uncomplicated, and could still be accomplished against one's will, and without legal, medical, or procedural safeguards.

With the development of state and public hospitals, wherein the mentally impaired could receive help for their problems, concomitant attention was given to the process of civilly committing one to such treatment. Prior to the mid 19th century, family members, police, physicians or others could easily commit the mentally infirm to involuntary treatment, solely on the basis that the person was "in need of treatment." It was generally assumed that family

members, and others, were acting in the patient's best interests and so little judicial involvement was deemed necessary. However, when state facilities began to proliferate, it became necessary to look at some controls for the process of civil commitment, and so the much needed, albeit immature, process of legislative purview was initiated. It now became more difficult for others to civilly commit the heretofore-disenfranchised "lunatics" and "insane," as the mentally ill now had the beginnings of a legal voice. No longer could greedy relatives collude with physicians to institutionalize their wealthy, but disparaged, family members (as was often purported to be the case), nor could troublesome family members be civilly committed without a modicum of due process (Appelbaum 1994).

Much like Clifford Beers, another former patient, Mrs. E.P.W. Packard, sought change with regard to the involuntary commitment of the mentally ill. She advocated for jury trials for those faced with civil commitment, so that the rationale for such action could be formally adjudicated. The work of Mrs. Packard, combined with that of others, had the effect of requiring hearings for the mentally ill—including those at private hospitals. It also impacted the medical aspect of commitment by requiring physicians to actually examine potential candidates prior to proceedings for commitment, as well as sign an affidavit that noted that the physician did not stand to gain financially from such an action (Appelbaum 1994; Szasz 1963).

The public attention afforded the process of involuntarily detaining patients waxed and waned according to the political emphasis of the times. When those advocating rapid hospitalization brought their message to the fore, the push for judicial reform and addition of stringent controls was reduced. However, when a more civil libertarian approach was promoted, protective, legal statutes took the spotlight, and the push for change intensified. Indeed, the first half of the twentieth century saw an abundance of the former, as more and more concern was

expressed over patients having to endure legal hearings more reminiscent of criminal proceedings than expeditious treatment for the mentally ill. Social activists proposed that the power of civil commitment be transferred away from the court and into the domain of medicine. Using a medico-legal model, one or two physicians would assume the authority to make such decisions, with a patient having an after-the-fact hearing only if he/she so desired. Some states adopted such statutes. Others elected to continue with mandatory judicial hearings, but left an as yet unmentioned, although significant, problem in the hands of judges. The problem, that of the judge deciding whether or not to inform civil commitment candidates about their hearings, was ever salient, and became the crux of future judicial decisions with regard to involuntary commitment (Appelbaum 1994).

The legislative reform of involuntary commitment laws has been, like most legal major decisions, more a process than an event. Various tenets have influenced that process and have been reflected through the years in numerous decisions made on state and Supreme Court levels. Applebaum (1997), in one of his many looks at the laws and process of civil commitment, sums up the reforms made from 1964-1979:

> These forces, taken as a whole, culminated in a radical transformation of the law of civil commitment that essentially altered the status quo in every state in the nation over the course of 15 years. Use of involuntary commitment was limited to persons who were likely to be dangerous to themselves or others, the latter category including those so impaired as to be unable to meet their basic needs. The law allowing hospitalization of persons solely because they were "in need of treatment"—the historic standard of commitment in this country—was abandoned. In addition, a set of procedural rights was imported from the criminal law, including rights to a hearing, notice, representation by an attorney, to testify on ones' own behalf, to call and cross-examine witnesses, and to exclude evidence that did not meet the ordinary standards of admissibility. Although states varied in the details of their statutes, the basic thrust of the reforms was similar in every state.

Reactions to the dramatic changes in the rights afforded to those presumed mentally ill were varied. Embraced by some, and eschewed by others, subsequent civil commitment law has

been examined, reexamined, commented on, challenged, and explored at length in the literature. Indeed, the topic of civil commitment can elicit some very strident opinions from those familiar with the process of treating and protecting the rights of the mentally ill.

The process of formulating laws to protect the rights of the mentally ill has not been without debate. Disparate views have marked the judicial/mental health landscape, and have been alternately responsible for bringing discrete agendas to the fore and influencing the direction of the legislation at the time. The strata of opinion with regard to the rights of those who may be in need of mental health treatment is much more complex than the dichotomous presentation of civil libertarians vs. those who advocate for more protective positions of the right, or need, to treat those so afflicted. It is doubtful that anyone familiar with the tenets of the individual arguments would consider them totally and mutually exclusive. And yet two basic positions have emerged with regard to the rights afforded those who suffer from mental impairment. For the purposes of this proposal, those positions have been titled Civil Libertarians, those advocating against what they consider legally sanctioned coercion, and "Dying With Rights On," a term made popular by a Wisconsin psychiatrist by the name of Darryl Treffert, an early critic of civil commitment law reform (Appelbaum, 1994).

States have long struggled to find a balance between protecting the civil liberties of their mentally ill, while ensuring that opportunities for treatment (however mandated) are extended to those in need of such services. Aviram & Weyer (1996) offered a succinct conceptualization of the debate in the opening of their paper *Changing Trends in Mental Health Legislation: Anatomy of Reforming a Civil commitment Law.* They wrote: "During the past twenty-five years, U.S. public policy involving civil commitment of persons with mental illness swung like a pendulum between two opposing poles: the medical-psychiatric and the legal models. The former

emphasizes medical considerations of a person's need for treatment and allows easier commitment to psychiatric institutions; the latter focuses on legal procedural safeguards and protection of civil liberties during commitment proceedings and makes commitment more restrictive." Aviram & Weyer (1996) highlight the evolving and often alternating trends of civil libertarian approaches and social service orientations in their paper, and note that the special interests of the parties shaping mental health legislation are often outside the mental health system.

Because this proposed study will originate from the state of Oklahoma, a look at the state's mental health laws is included. The Department of Mental Health and Substance Abuse Services publishes and disseminates the Emergency Detention Manual & Guidelines for the state of Oklahoma (DMHSAS, 1997). The introduction of the manual sums up the purpose and intent of Oklahoma's mental health law as it applies to emergency detention.

> The purpose of the Oklahoma Mental Health Law is to provide for the humane care and treatment of persons who are mentally ill or who require treatment for drug and alcohol abuse. All such residents of this state are entitled to medical care and treatment in accordance with the highest standards accepted in medical practice.
>
> There are circumstances which justify the taking of an individual into protective custody for the purposes of initiating emergency detention proceedings. The emergency detention proceedings should be initiated only when there are no other acceptable alternatives for individuals who appear to be in need of treatment for mental illness or substance abuse. The emergency detention process is designed to ensure an individual receives appropriate treatment in addition to protecting the individual or other persons from dangers resulting from the mental illness or substance abuse.
>
> Protective custody and emergency detention are utilized as temporary measures for the speedy processing of emergency situations with the objective of suppressing and preventing conduct which is likely to create a clear and present danger to the individual or other persons. Emergency detention must not be utilized merely as a convenience to the parties involved in a particular situation. Under the police powers of the state, the right to initiate an emergency detention has been upheld by the courts. However, protective custody, emergency detention, and involuntary commitments deprive individuals of their liberty and should not be taken lightly. Therefore, constitutional due process is afforded to individuals subject to the emergency detention process. The due process includes, but is not limited to, the right to notice, the right to

counsel, the right to jury trial, the right to be present in the hearing, the right to present and cross-examine witnesses, and the right to challenge detention through a habeas corpus action.

It is the responsibility of law enforcement, the judicial system (judges, prosecutors, and defense attorneys), and mental health professionals to ensure that individuals falling within the jurisdiction of the Oklahoma mental health laws are afforded their constitutional and statutory rights.

As with most legal documents, the laws that govern the judicial process afforded to those who face involuntary detention are copious and extensively worded. Nevertheless, the basics of Oklahoma's most salient emergency detention laws, and the associated rights of those facing them, can be briefly summarized by the following:

1. A person placed in protective custody must be examined by a licensed mental health professional within 12 hours of being taken into custody to determine if emergency detention is warranted.
2. If emergency detention is warranted, the licensed mental health professional shall prepare a statement describing the findings of the examination and stating the basis for the determination. The statement will be in the form provided by the Department of Mental Health and Substance Abuse Services.
3. The licensed mental health professional shall provide for a full examination and evaluation of the person by two licensed mental health professionals.
4. A person may be detained in emergency detention more than 72 hours only if the facility is presented with a copy of an order of the district court authorizing further detention.
5. If a copy of an order for further detention is not delivered to the facility by the end of the period of emergency detention, the person requiring treatment shall be discharged unless said person has applied for voluntary treatment.

6. The person alleged to be mentally ill has the following rights: right to notice, right to counsel, right to a hearing, right to a jury trial if requested, right to be present at the hearing or trial and the right to present and to cross-examine witnesses.
7. The attorney appointed by the court for persons who have no counsel shall meet and consult with person within one day of the notification of the appointment and shall present to the person their rights as stated by the Oklahoma and United States constitutions.
8. If the person is found at the hearing to be mentally ill and requiring treatment, the court will take evidence and make findings of fact concerning the person's competency to consent or to refuse the treatment that is ordered, including the right to refuse psychotropic medications.
9. The person delivering the copy of the notice and petition to the person alleged to be mentally ill shall, at the time of delivery, explain the content, purpose and effect of the notice and the legal right to judicial review by habeas corpus.
10. A copy of the notice and the petition shall be delivered at least one day prior to the hearing to: the individual initiating the request for protective custody; the attorney representing the alleged mentally ill person; the district attorney; the facility in which the person is detained; the Department of Mental Health and Substance Abuse Services; and a parent, spouse, guardian, brother, sister or child of the person alleged to be mentally ill who is at least 18 years of age and who did not initiate the petition.
11. The notice may be served personally or by certified mail.

12. The period of prehearing detention shall not exceed 72 hours, excluding weekends and holidays. Prehearing detention may be extended to coincide with any order of continuance entered by the court.
13. The court, at the hearing on the petition, shall determine by clear and convincing evidence whether the person is a mentally ill person and a person requiring treatment.

With the basics of Oklahoma's emergency detention law outlined, it is time to turn to whether those laws, and others like them, are carried out—whether the spirit and the letter of the law coincide in any meaningful way. And that leads us to the question of whether the rights of the mentally ill are truly are protected under the law as it is written. There are those who maintain that current judicial mandates adequately protect the rights of those mentally ill who have fallen under the purview of mental health law. In his paper on the subject, one sociologist stated: "Compulsory detention in a psychiatric hospital constrains, but does not remove the rights of those admitted. The mental health laws of different countries provide for various mechanisms intended to protect the rights of detained patients." (Barnes, 1996). Others, even while acknowledging years of reform, disagree.

Perlin, Guld & Derfman (1996) cite case law that found that the same "fundamental liberties" in criminal cases are at stake in civil commitment proceedings. And yet, the authors point out, "....traditionally, involuntary civil commitment procedures have not assured the due process safeguards against unjustified deprivation of liberty that are accorded those accused of a crime." Moreover, they state that "For those with mental disabilities, there is a dearth of competent counsel." Perlin et al. attribute this to ignorance of the law, fear of their clients, and feeling responsible for the acts of their clients. As a result, they note that attorneys do not

"zealously" represent their mentally ill clients, and instead represent "what they—the attorneys and the advocates—feel is in the client's best interest or in society's best interest."

Such "best interest" representation is at the heart of "*parens patriae*"—a legal power used by states to justify their decisions to involuntarily detain or commit mentally ill individuals. Some feel that the parens patriae power is broadly used to also label the mentally ill as when, in the process of civil commitment, individuals are labeled incompetent. Winnick (1996) advocates a more limited use of parens patriae in the area of competency. "The adverse effects of incompetency labeling are sufficiently serious that in many contexts, application of the label should be regarded as a deprivation of liberty within the meaning of the Constitution. As a result, in such contexts, the state's ability to use its parens patriae power, which requires labeling an individual incompetent, should be limited. In these contexts, constitutional considerations suggest that incompetency should be defined more narrowly, that competency should be presumed, and that the burden of persuasion should be placed on the party that asserts incompetency."

Some social scientists argue that the *process* whereby individuals are involuntarily detained impacts the detainee more than the actual detention. The psychological consequences of the judicial procedures themselves, asserts Tyler (1996), highly influence how the mentally ill view imposed restrictions on their freedom, and are highly relevant to the laws as they now stand. As quoted earlier in this paper, "People's evaluations of the fairness of judicial hearings are affected by the opportunities which those procedures provide for people to participate, by the degree to which people judge that they are treated with dignity and respect, and by judgments about the trustworthiness of authorities. Each of these factors has more influence on judgments

of procedural justice than do either evaluations of neutrality or evaluations of the favorableness of the outcome of the hearing."

While investigating the effects of civil commitment on involuntary patients, Kjellin, Anderson, Candefjord, Palmstierna and Wallsten (1997) found an association between perceived respect for autonomy by authorities and self-reported improvement in mental health. They note that "The aim of both involuntary and voluntary psychiatric care must be to achieve as many benefits as possible at the lowest [ethical] cost." Other researchers cite problems with the implementation of current involuntary commitment laws. Husted and Nehemkis (1995) studied civil commitment from the perspectives of police, professionals, and families and found that "there is a difference in the subjective understanding of the criteria as delineated in the law. This is demonstrated by the fact that the two main groups who are responsible for initial implementation of the laws—emergency room mental health staff and police offers in the community, significantly disagree on when these laws may be applied."

Others note that even when it is clear that the law needs to be applied, it may be done so in the direction of commitment, but not in the direction of protecting the rights of those being committed. Osuna, Cuenca, Perez-Carceles and Luna (1995) addressed the legal status of the chronically ill and noted that "The spirit of the current legislative framework is to protect persons with mental illness and to guarantee each and every one of their rights. However, it should be recognized that promulgation of a new law is not tantamount to its enforcement." Appelbaum (1997) took an international look at involuntary commitment laws and said that "The key to understanding the difference between commitment law on the books and commitment law in practice is to recognize that laws are not self-enforcing. Indeed, implementation of involuntary hospitalization is delegated to a variety of participants in the commitment process, all of whom

have the potential to affect how the law is applied. When the results of a law narrowly applied will be contrary to the moral intuitions of these parties, they will act at the margins to modify the law in practice to achieve what seem to them to be more reasonable outcomes."

Applebaum (1997) supports his contentions by citing several pertinent studies. In one study, even though the very narrow terms of California's commitment law were not met, Warren (as cited by Applebaum) found that one judge applied "commonsense notions to his decisions." In another study Hiday and Smith (as cited by Applebaum) found that "in 47.5% of commitment cases in which the petition lacked any information concerning the statutory dangerousness criteria, respondents were committed anyway." Applebaum contends that failure to abide by commitment laws is also a problem for attorneys who represent the mentally ill. He cites a study by Poythress who trained lawyers in challenging expert testimony at commitment hearings. Poythress (as cited by Applebaum) found that "none of them used the training, because they did not see it as their job to achieve the release of people whom they viewed as genuinely ill." Another study cited by Applebaum had similar findings. Warren (as cited by Applebaum) found that attorneys "were not often playing the adversarial role anticipated by the law." Bottomley (as cited by Applebaum), found that "many lawyers.....elect to argue for their version of patients' needs rather than for patients' expressed wishes to be released. Lawyers' presence does not guarantee an adversarial proceeding."

Applebaum (1997) notes that the problem does not just rest with legal participants. "With judges and lawyers who are trained to be respectful of individual rights bending the law when that seems to be necessary for patients to receive treatment, it is no surprise that psychiatrists, whose primary interest is in providing treatment, do the same. Reviews of commitment petitions completed by psychiatrists and other mental heath professionals routinely reveal a failure to

specify legally required criteria in a large percentage of cases: 16.1% in a North Carolina study of cases that led to judicial commitment; even higher numbers in a set of Canadian studies" (Hiday & Smith; McCready & Merskey; Page & Yates, as cited by Applebaum).

Rubin, Snapp, Panzano and Taynor (1996) found that there are many factors which influence the implementation of mental health law, and that these factors may vary within individual states operating under the same legal code. Some of the factors include: judges' interpretations of the legal code; clinicians' attitudes about involuntary treatment; judges' attitudes about outpatient commitment as an alternative to involuntary hospitalization; service providers' liability concerns; the organizational structure of the local mental health delivery system; attorneys' assumptions of adversarial versus paternalistic positions in the courtroom; law enforcement officials' levels of cooperation, and the communities' demographic characteristics. Bursztajn, Hamm and Gutheil (1997) have also looked at which factors influence the implementation of civil commitment laws. In a single case study of a judge's decision process for civil commitment, they found that the judge considered factors not directly specified by the law. "Among the specific factors this judge used in considering whether the law's general principles applied in each case were the patient's competence, predictability, and reliability as an outpatient, as well as whether family and friends favor commitment."

Certainly, the medico-legal decision to involuntarily commit a person to treatment is not an easy one. Anderson and Eppard (1995) studied psychiatrists, nurses and counselors with regard to clinical decision making during assessment for involuntary psychiatric admission and identified nine structural elements: "The process of clinical decision making for involuntary psychiatric admission is systematic, cautious, and individualized. It is important to connect with the client and use intuitive reasoning. State-mandated criteria must be met, and treatment

alternatives considered. All contingencies cannot be controlled. The decision to involuntarily admit a patient is never made alone." The preceding criteria appear to meld well with both the spirit and the letter of our current laws, which mandate a thorough, well-documented process that includes procedural safeguards to protect the rights of those most intimately affected by commitment decisions. Eriksson and Estrin (1995) though, found that the patients they surveyed felt a sense of "fait accompli" with regard to the coercive measures involved in the commitment process. Indeed, 51% of the surveyed patients who were committed reported that "they had been violated as a person/human being."

Oklahoma, like many other states, has seen lawsuits related to issues surrounding the detention of the mentally ill. One such lawsuit was explored in the *Opinions of the Oklahoma Supreme Court* (1997), and is officially known as Wofford vs. Mental Health Services, Inc. Court records show that Dawn Wofford was feeling suicidal on the night of October 29, 1990, and subsequently voluntarily admitted herself to Parkside Hospital. Earlier in the evening she had been refused admission at another hospital because of a lack of insurance. As part of the admission process at Parkside, Mrs. Wofford signed a consent form that stipulated the conditions of her voluntary discharge from the hospital. Her signature acknowledged that to be released, she would be required to submit a written request to the administrator and the medical director of the hospital, and that the hospital would be allowed to hold her for only 3 days after her written request.

Approximately 12 hours after her admission, Ms. Wofford requested, in writing, that she be released from Parkside Hospital. On November 2, 1990, 4 days after her admission, an order allowing Parkside to detain Ms. Wofford was filed with the court. Mrs. Wofford responded by filing a writ of habeus corpus, after which the hospital released her. When one examines the

dates of Ms. Wofford's entrance and exit from Parkside, it is apparent that the hospital held her for only one day past the mandatory 3 days stipulated in the consent form she signed. Nevertheless, a lawsuit for false imprisonment was filed and ultimately won by Mrs. Wofford. Due to procedural problems involving the various judges who had heard the 5 year long case, the verdict was later overturned on appeals. However, at the conclusion of the appeals trial, and after the jury was discharged, one of the Supreme Court judges hearing the case made the following statement to the assembled plaintiff and defendants:

> I think that what you did to this woman was absolutely outrageous and a disgrace to your system and a disgrace to my system. This hospital had no authority to keep this woman, mentally ill or not, without following court procedures, good intentions or not. And I think that's outrageous. And I hope-you know, I certainly respect this jury's verdict, but I hope, because you walk out of here scott free, that you don't take that as a license to continue to falsely imprison people like Mrs. Wofford. I am absolutely appalled. And, again, I have some faith that you will do whatever you need to do to straighten that out.

The hypothesis was developed that, although current mental health law was designed to carefully protect the rights of mentally ill individuals, the letter of the law and its practice do not consistently coincide in such a way as to fulfill the purpose and intent of the law. Judges are legally and ethically responsible for ensuring that the rights of the mentally ill are protected with regard to decisions made in their (the judges) courtrooms. A lack of training in mental health law and/or a lack of training in understanding abnormal psychology may account for this variance. Anecdotal observations point to several deficiencies with regards to how the rights of the mentally ill are carried out. Most notably they include:

1. Sections of the legal, notarized paperwork are filled in by those other than licensed mental health professionals. Often sections are left blank and/or do not give the information requested by the court.

2. Judges appear to trust that the examinations of the mentally ill and the attendant paperwork have been completed as mandated by law, and make decisions based on those assumptions.
3. When patients do not appear to meet the criteria of dangerousness to self or others, or as being unable to care for their own basic needs, judges often commit.
4. When patients' presentations are contrary to what the Licensed Mental Health Professional's statement outlines, the statement is generally considered more relevant.
5. The adversarial process dictated by law is not present in involuntary commitment hearings.
6. The mentally ill are often not informed of their rights, and a member of the family is rarely notified, as specified by law.

C. Rationale

Given the above considerations, the research proposed herein has the potential for significant practical value. Researching the training practices of future attorneys by law schools with regard to mental health law and abnormal psychology may shed light on possible training deficits. Further, this research has the potential to integrate current knowledge regarding the involuntary commitment process with recommendations for training. Given that there is evidence that mental health patients respond to involuntary treatment better when they perceive the process as being administered fairly, the potential information gleaned from this study could help point to the need for better and more specific training in mental health law and abnormal psychology for the attorneys and judges who carry out the law's mandates by making decisions regarding the freedom or commitment of the mentally ill.

II. SPECIFIC AIMS AND HYPOTHESES

A. Aims

The specific aims of this study are: 1) to survey the training directors of American Bar Association and American Association of Law Schools accredited training programs to determine the percentage of training programs that require training in mental health law; 2) to survey the training directors of American Bar Association and American Association of Law Schools accredited training programs to determine the percentage of training programs that require training in abnormal psychology; 3) to determine what methods are used to train attorneys in recognizing mental illness; 4) to determine how much training attorneys receive in mental health law and abnormal psychology; 5) to determine if electives are offered in the areas of mental health law and abnormal psychology; and 6) to formulate training recommendations for American Bar Association and American Association of Law Schools accredited law programs in the areas of mental health law and abnormal psychology.

Hypotheses

Null Hypotheses:

1) More than fifty percent of American Bar Association and American Association of Law Schools accredited training programs will provide training in mental health law and abnormal psychology.
2) Those offering training will mandate one or more courses in both mental health law and abnormal psychology.
3) There will be no need for recommendations for strengthening attorney/judge preparation in the areas of mental health law and/or abnormal psychology.

Alternate Hypotheses:

1) Less than fifty percent of American Bar Association and American Association of Law Schools accredited training programs will provide training in mental health law and abnormal psychology.
2) Those offering training will do so on an elective basis.
3) There will be a need for specific recommendations regarding training in the areas of mental health law and abnormal psychology.

III METHOD

A. Selection of Subjects

A list of American Bar Association and American Association of Law Schools accredited training programs will be used for this research study. Research packets will be mailed to the training directors of all American Bar Association and American Association of Law Schools accredited training programs in the United States (171) during the month of October, 2000. Full research packets will be sent in a follow-up mailing, approximately 6 weeks later, to those who do not respond to the initial mailing.

B. Procedure

The training directors will be asked to complete a short survey that will cover the objectives of the study (copy attached). A stamped and addressed envelope will be provided to the training directors to return the completed survey.

C. Human Experimentation Considerations

Although this study proposes to investigate the mental health law and abnormal psychology training provided to law school students, it is believed that the study's design will preclude an undue stress to subjects. Further, given that American Bar Association and American

Association of Law Schools accredits these institutions their curriculum and training practices should lend themselves to some scrutiny.

Before completing the study each subject will be asked to read and sign a consent form. No direct benefits to participants are provided as part of this research. Participants will be made aware of all human subjects rights, including the voluntary nature of participation. There is no deception in any of the research procedures. No direct risks have been identified for potential respondents. A certification of participant consent will be included in each research packet. Results will be available to participants upon request.

IV. STATISTICAL ANAYSIS OF DATA

Analyses for this exploratory study will largely be descriptive in nature, and will be used to describe the current training practices of accredited Law Schools in the areas of mental health law and abnormal psychology. Correlational analyses will be conducted in order to examine the relationships between training institution variables, including the student population of the institution, number of students in the ABA and AALS accredited program, number of full-time faculty, and number of part-time or adjunct faculty. A logistic regression analysis will also be conducted to determine those particular variables that might help explain why certain training programs offer training in mental health law and abnormal psychology while others do not.

The University of Oklahoma

Graduate College

Authority Report Form for Final Oral Examination (Dissertation Defense) for Gail Poyner

Date Released by Graduate College 6-4-01

Professor Terry Pace:
You are hereby informed that permission has been given to Ms.Gail Poyner, 551-17-3630, to appear for the final oral examination (dissertation defense) 10 working days after the date above, but no later than the last day of classes for the semester in which this authority is issued. Remember, only one attempt at defending the dissertation is permitted.

As chair of this committee, it is your duty to consult with the candidate and the other members of the committee to select a definite date for the examination, to ensure that each member of the committee received a reading copy at least 10 working days before the examination, to conduct the examination, and to certify the results of the examination to the Dean of the Graduate College. Since the examination may be given before the regular final examination period, the committee should make it clear to the candidate that she is not excused from taking her course examinations; moreover, she must maintain the grade average required for graduation. The candidate is responsible for giving each member of her committee an opportunity to read and evaluate the dissertation (or document) before the examination. This report, duly signed by all members of the examining committee reporting the candidate's performance whether it be satisfactory or unsatisfactory, is due in the Graduate Dean's Office within 72 hours following the examination.

Dean, Graduate Office

Special Note to : The authorization for the defense of the dissertation is given with the proviso that you are enrolled in a minimum of two credit hours of dissertation research for the semester in which this authority is given.

To the Dean of the Graduate College:

We, the undersigned members of the doctoral committee, met on 6/7/01 (Date) and have examined a candidate, Gail Poyner, for the degree of Counseling Psych.-Ph.D., and report the following results:

SATISFACTORY

~~UNSATISFACTORY~~

Name	Signature
Terry Pace ,Committee Chair	
Denise Beesley	
Bridget Murphy	
Jason Osborne	
Cal Stoltenberg	

I dissent from the foregoing report for the following reasons: