Procedural Safeguards for Periodic Review:  
A New Commitment to Mental Patients’ Rights

During the past decade, state and federal courts have begun to explore the degree of protection that the Constitution guarantees to mental patients in the civil commitment process. In *Fasulo v. Arafeh*, the Connecticut Supreme Court became the first high court to find a constitutional requirement of periodic review for civilly committed patients.

1. The Supreme Court has decided eight cases touching on civil commitment procedures, half of which have appeared in the last six years. See *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975) (continued confinement of nondangerous patient who is not receiving treatment violates "constitutional right to freedom"); *McNeil v. Director of Patuxent Inst.*, 407 U.S. 245, 249-50 (1972) (denial of due process to continue to hold indefinitely for observation without procedural safeguards); *Jackson v. Indiana*, 406 U.S. 715, 730 (1972) (denial of equal protection for criminal defendant found incompetent to stand trial to be committed without same procedural safeguards afforded to civilly committed); *Humphrey v. Cady*, 405 U.S. 504, 511-12 (1972) (remand to decide whether equal protection demands that renewal of commitment order originally issued in lieu of criminal sentence must be governed by same procedures as civil commitment); *Specht v. Patterson*, 386 U.S. 605, 610 (1967) (conviction as sex offender under one statute may not constitutionally lead to additional commitment without procedural safeguards); *Baxstrom v. Herold*, 383 U.S. 107, 115 (1966) (judicial review required prior to civil commitment at expiration of prison sentence); *Lynch v. Overholser*, 369 U.S. 705, 711-12 (1962) (when defendant has not pleaded insanity but has been acquitted on such grounds, hearing required before commitment); *Minnesota ex rel. Pearson v. Probate Court*, 309 U.S. 270, 274 (1940) (statute committing persons with psychopathic personalities not unconstitutionally vague); *cf. Texas v. Addington*, 557 S.W.2d 511 (Tex. 1977), *prob. juris. noted*, 435 U.S. 967 (1978) (Supreme Court to hear question of standard of proof in civil commitment cases).


3. Few other courts have commented on the need for periodic review. See *id.* at 479-81, 378 A.2d at 556-57. For a post hoc review of periodic review, see *But see Suzuki v. Quienerberry*, 411 F. Supp. 1113, 1133-34 (D. Hawaii 1976) (dictum) (Constitution requires periodic review). It has been suggested that this lack of attention can be explained by the fact that most patients are discharged “relatively quickly” as the result of informal hospital administrative action. *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1198, 1377 (1974) [hereinafter cited as *Developments*]. See *National Institute of Mental Health, Length of Stay of Admissions to State and County Mental Hospitals United States 1971*, at 2 (1973) (statistics indicate substantial number of long-term commitments); *Crane, Zonana*. 850
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Despite an increasing perception that periodic review is necessary, there has been relatively little discussion of how this review should be implemented. Few commentators have focused on two distinct purposes for civil commitment: preventive detention and treatment of the mentally ill. Yet every state has based its standard for commitment on one or both of these alternatives.

& Winer, Implications of the Donaldson Decision: A Model for Periodic Review of Committed Patients, 28 HOSPITAL & COMMUNITY PSYCH. 827, 832 (1977) (study shows significant number of long-term patients inappropriately placed in Connecticut state mental hospital). Moreover, several state statutes authorize only a limited term of commitment. See, e.g., CAL. WELF. & INST. CODE § 5304 (West Supp. 1978) (90 days); N.Y. MENTAL HYG. LAW § 9.33 (McKinney 1978) (one or two years). Although over 30 states require some type of periodic review, it is usually internal hospital review. See Developments, supra, at 1382-83.


5. But see, e.g., Fasulo v. Arafeh, 173 Conn. 473, 378 A.2d 553 (1977); Developments, supra note 3, at 1376-98.

6. See O'Connor v. Donaldson, 422 U.S. 563, 573-74 (1975) (outlining recognized rationales for civil commitment); Jackson v. Indiana, 406 U.S. 715, 737 (1972) (same). These two purposes are reflected in legislative standards governing civil commitment. A preventive detention standard covers those who are mentally ill and who are either dangerous to themselves or others, or “gravely disabled.” See, e.g., CAL. WELF. & INST. CODE §§ 5260, 5300 (West 1972); CONN. GEN. STAT. § 17-178 (1977). “Gravely disabled” is usually defined as unable to care for one’s basic needs. See, e.g., id. § 17-176. A therapeutic standard usually authorizes the commitment of people found to be mentally ill and in need of care or treatment. See, e.g., DEL. CODE ANN. tit. 16, § 5010 (Supp. 1977); GA. CODE ANN. §§ 88-506.2 (Supp. 1978).

Some of these states qualify “in need of treatment” by specifying that the patient must be incapable of making his own treatment decision. See, e.g., UTAH CODE ANN. § 64-7-36(6) (1978). The standard requires a determination of whether the patient is competent to make a rational treatment choice. If the patient is not competent, the state makes the treatment choice for him. But this determination of capacity and any subsequent proxy treatment decision are really determinations of how seriously the patient needs treatment. The court judges capacity by examining the reasonableness of the patient’s refusal to accept treatment. This judgment probably hinges on evaluation of the patient’s symptoms and their susceptibility to treatment; thus the judge looks at how badly the patient needs treatment.


This Note analyzes the policy and constitutional considerations that a legislature should take into account in implementing a periodic review program. It suggests that both the policy and the constitutional arguments for the three basic procedural safeguards mandated in *Fasulo* are far more compelling under a preventive detention standard than under a therapeutic one. The Note recommends the adoption of all three of the *Fasulo* safeguards when the purpose of commitment is preventive detention, but only two when the purpose is therapeutic. It also proposes evidentiary rules that will further aid in the implementation of periodic review.

I. *Fasulo* and Considerations for Periodic Review

In most states, the mentally ill can be involuntarily hospitalized for an indefinite length of time either by order of a panel of psychiatrists or by judicial decree. The decision to commit hinges on meeting one or both of the two basic standards for commitment, “dangerousness” or “in need of treatment.”

Release is usually at the discretion of the hospital superintendent, but in rare instances, review by petitions for habeas corpus is used to

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1. *Fasulo* held that periodic review must be implemented by a state-initiated, judicial hearing in which the state must bear the burden of proof. *Id.* at 481-82, 378 A.2d at 556-57. As a possible fourth safeguard, *Fasulo* added in dictum that the hearing should be nonwaivable. *Id.* at 556-57.

9. See Developments, supra note 3, at 1268-70.
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obtain release. These patient-initiated petitions can trigger hearings in which the patient must carry the burden of demonstrating that he no longer requires hospitalization.

A. Fasulo

Fasulo held that the due process clause of the Connecticut constitution requires state-initiated periodic review to ensure the prompt release of patients who no longer need hospitalization. Although Fasulo was technically decided under state law, its rationale may also govern federal constitutional analysis because the Connecticut due process clause is essentially identical to its federal counterpart, and because the Connecticut court relied primarily on the United States Supreme Court's interpretations of the Fourteenth Amendment. Because of Fasulo, and the possibility of similar holdings in other jurisdictions, legislatures will need to consider how to design a statute that comports with this due process requirement while also fulfilling the chosen state goals that support civil commitment.

B. Flaws in the Fact-Finding Process

A number of problems in the civil commitment process must be taken into account in order to design effective procedural safeguards. These include the inherent biases of the several possible triers of fact, the disabled condition of the patient, the state's superior access to and control over much of the evidence, and the ambiguity of the standards for commitment.

Psychiatrists and judicial officers traditionally have been employed in commitment proceedings as arbiters or triers of fact. But each group has its own bias that calls into question its ability to perform the role. Potential psychiatric arbiters fall into three classes: the patient's own physician, another hospital staff psychiatrist, or an unaffiliated psy-
Each class may suffer from a systematic predisposition with respect to the release decision. The patient's own psychiatrist may be careless, motivated to conceal past mistakes, or simply too busy to conduct adequate periodic review of seemingly chronic patients. Other state hospital psychiatrists may be reluctant to interfere with a colleague's decision, because of professional courtesy, fear of future consequences, or loyalty to the institution.

Psychiatrists in general, including those who are not affiliated with the hospital, will tend to favor treatment for all those who need it. This might lead a psychiatric hearing officer to decline to release a patient who is in need of treatment, regardless of the standard for commitment. Medical ethics may conflict with the law when a physician has a legal duty to discharge a patient who needs treatment and who may be harmed to some degree by release. In addition, physicians may be subject to civil suit for an erroneous determination when a released patient injures a third party. Judges, by contrast,


17. It has been widely suggested that psychiatrists in state mental institutions are not sufficiently diligent in finding satisfactory alternatives to hospitalization. See, e.g., A. Strauss, L. Schatzman, R. Bucher, D. Ehrlich & M. Sabshin, Psychiatric Ideologies and Institutions 116-17 (1964) [hereinafter cited as A. Strauss]; Crane, Zonana & Wizner, supra note 3, at 832-33; cf. pp. 866-67 infra (hospital should be required to find alternatives).

18. The commentary to § 1 of the American Medical Association, Opinions and Report of the Judicial Council 8 (1960) [hereinafter cited as Opinions and Report] provides that "[a] physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed."


20. See R. Veatch, Case Studies in Medical Ethics 59-61 (1977) (implicit loyalty to institution creates conflict with physician's relationship to patients); Shestack, supra note 19, at 9-12 (same).


22. For example, the Hippocratic Oath provides that the physician will not use his training in a manner that will in any way harm his patient. See A. Campbell, Moral Dilemmas in Medicine 194-95 (1972). Yet releasing a patient the psychiatrist knows is dangerous in order to provide treatment.

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usually enjoy immunity from such suits, but lack medical knowledge and usually defer to the judgment of medical witnesses when psychiatric questions are presented.

Another difficulty arises because the patient himself may be hampered from communicating and producing evidence by his disabled condition. Moreover, the mentally ill are commonly stereotyped as dangerous, and their often bizarre appearance may reinforce that stereotype in the mind of a lay arbiter.

A third problem is the hospital's control over virtually all relevant evidence. A hospital can manipulate both the contents of medical records and the testimony of hospital staff. Social workers and nurses, fearing dismissal, may be reluctant to testify contrary to the hospital administration's wishes.

(cause of action exists against psychiatrist when he fails to warn victim of danger posed by mental patient's release). But see Cameron v. State, 37 A.D.2d 46, 51, 322 N.Y.S.2d 562, 566 (1971), aff'd per curiam, 30 N.Y.2d 356, 282 N.E.2d 118, 331 N.Y.S.2d 30 (1972) (hospital has no "continuing duty to exercise parental role" after good faith release). In any event, the question is not the actual liability but the perceived liability that creates the psychiatrist's possible bias. Confusion as to what the rules of liability are will tend to have a chilling effect on the psychiatrist.


25. See Chayet, Legal Neglect of the Mentally Ill, 125 Am. J. Psych. 785, 790-91 (1968) (study at New York's Bellevue hospital reveals commitment judge follows state psychiatrist's recommendation in 75% of cases when patient is represented by counsel, and 97% of cases when he is not); Wexler, The Administration of Psychiatric Justice: Theory and Practice in Arizona, 13 Ariz. L. Rev. 1, 60 (1971) (Arizona study shows commitment judge follows state psychiatrist's testimony in over 96% of cases).

Possible bias might be mitigated if both parties present medical witnesses. The patient, however, will probably lack the resources to hire an expert witness. Moreover, assuming an expert witness is willing to testify on behalf of the patient, the judge does not have adequate training to give proper weight to the testimony of each psychiatrist. Consequently there is no assurance that the quality of decisions will be better when two psychiatrists testify, even if more patients are released.

The use of an independent psychiatric witness can prevent "hospital" bias. Several states permit or require such testimony. See, e.g., Conn. Gen. Stat. § 17-178(c) (1977) (requires); Wash. Rev. Code § 71.05.300 (Supp. 1977) (permits). An independent psychiatrist will still suffer, however, from "treatment" bias, see p. 854 supra, and may testify, even when in doubt, that a patient needs treatment. The judge may be unable to determine when the psychiatrist is in doubt.

26. To a substantial degree, this difficulty may be caused by the effect of drugs. See Comptroller General, Report to the Congress: Controls on the Use of Psychotropic Drugs and Improved Psychiatric Staffing Are Needed in Veterans Administration Hospitals 3, 4 (1975) (anxiety, tremors, loss of motor functions, restlessness); B. Ennis & R. Emery, supra note 21, at 73, 140-41.

27. See Slovenko, Criminal Justice Procedures in Civil Commitment, 28 Hospital & Community Psych. 817, 822 (1977); cf. Developments, supra note 3, at 1200 (many people have irrational fear of mentally ill).

28. See A. Brooks, supra note 10, at 791 (hospital has psychiatric expertise and opportunity to make record). Because the hospital is aware of the possibilities of litigation, it can develop an inaccurate written history of the patient's hospitalization.

29. Cf. R. Kharasch, The Institutional Imperative 33 (1973) (individuals who work in government positions may accept institutional judgment because they do not wish to be dismissed).
Even if an independent psychiatrist is appointed to examine the patient, he will likely to rely heavily on the hospital records, and will spend little time examining the patient himself. Consequently, the content of the hearing record will be for the most part the content of the hospital record.

The possibility of unintentional inaccuracies in the hospital record is substantial and the possibility of intentional inaccuracy cannot be discounted. The hospital psychiatrist often views independent hearings as unwarranted intrusions into the medical domain. Psychiatrists have even been known to withdraw medication from a patient prior to scheduled hearings in order to misrepresent the patient's condition.

Finally, the standards for commitment are vague. When the state's goal is preventive detention, a psychiatric prediction of dangerousness unaccompanied by evidence of a recent overt act is frequently deemed sufficient evidence to commit, even though it is not statistically accurate. Whenever the criteria for release are premised on the validity of such predictions, the application of the criteria to patients

31. See A. Brooks, supra note 10, at 791.
32. Inaccuracies in the hospital record may arise, inter alia, from inexpert observations of the nonprofessional staff who are in closest contact with the patient, see A. Strauss, supra note 17, at 249-55, and from a tendency to report and exaggerate only bad incidents, see B. Ennis & R. Emery, supra note 21, at 190.
33. See, e.g., A. Brooks, supra note 10, at 795 (quoting Davidson, Mental Hospitals and the Civil Liberties Dilemma, 51 Mental Hygiene 371 (1967)) (psychiatrist believes that protecting civil rights may be injurious to patient welfare); Siegert, Discussion, 131 AM. J. PSYCH. 222 (1974) (psychiatrists not acting responsibly when, in effort to avoid civil rights criticism, they hesitate to impose treatment believed to be in patient's interest).
34. See B. Ennis & R. Emery, supra note 21, at 193.
36. See Kozol, The Diagnosis and Treatment of Dangerousness, 18 Crime & Delinquency 371, 372 (1972) (statistics show psychiatrists unable to predict dangerousness accurately without past history of violence); cf. B. Ennis & R. Emery, supra note 21, at 45 (statistics show that diagnosis of mental illness does not increase statistical likelihood of violence).
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will probably be arbitrary. Furthermore, there is no scientific consensus concerning what medical evidence should be sufficient to support a finding of dangerousness. Vagueness in both standards also stems from the wide latitude that can be given to the words "mentally ill," and procedural safeguards are necessary to define and apply the concept more precisely.

II. Solutions: Procedural Safeguards for Periodic Review

In order to develop an effective legislative solution to potential problems of periodic review, it is necessary to establish whether the hearing mandated in Fasulo is to be nonwaivable, to determine the best trier of fact, to allocate the burden of proof, and to prescribe a set of evidentiary rules. The choices made will stem in part from the civil commitment goal or goals that the state chooses.

A. A Nonwaivable Hearing

Legislatures should mandate that the required periodic review hearing be nonwaivable. Only a nonwaivable hearing will adequately im-

37. See B. Ennis & R. Emery, supra note 21, at 46 (attorneys involved in civil commitment believe dangerousness standard arbitrarily applied). But see Monahan, Prediction Research and the Emergency Commitment of Dangerous Mentally Ill Persons: A Reconsideration, 135 Am. J. Psych. 198 (1978) (psychiatrist suggests circumstances surrounding short-term emergency commitment of persons predicted to be imminently dangerous may allow greater statistical accuracy in prediction than found in commitment generally).

38. Clinicians may base their predictions of dangerousness upon various factors. A recent overt act is often used. R. Rock, supra note 30, at 240. In the absence of an overt act clinicians have theorized dangerousness on the basis of morbid jealousy; a sense of helplessness coupled with rage; a combination of enuresis, firesetting, and cruelty to animals; a history of parental violence; drug or alcohol usage; and hypersensitivity to close body contact. See A. Stone, supra note 19, at 30. But most of these theories have been criticized as poorly documented, and it has been hypothesized that most psychiatrists rely primarily on their own intuition rather than mechanical tests. See id.; cf. pp. 865-66 infra (overt act should be required before dangerousness can be found).

39. See In re Ballay, 482 F.2d 648, 665 (D.C. Cir. 1975) (dictum) (psychiatrists define mental illness in terms of deviating from social norm); T. Szasz, The Manufacture of Madness 68 (1971) (same). Virtually everyone differs somewhat from the social norm. Thus a person may well be mentally ill and need treatment, but still be able to live safely in freedom. Cf. O'Connor v. Donaldson, 422 U.S. 563, 575 (1975) (state not justified in involuntarily confining persons who are mentally ill but who are harmless).


41. See p. 851 supra.
plement the patient's right to periodic review. Mental patients are generally ignorant of their rights. When patients wish to leave the hospital, they will usually be subjected to institutional pressure that may prevent them from exercising that right. Even if a patient actually chooses to forego periodic review, he may be incapable of a knowing waiver. A mandatory hearing thus protects the patient's rights and avoids any implication of noncooperation that may arise from not waiving state-initiated review.

B. The Trier of Fact

Although the trier of fact ought to be neutral, all candidates for that position have some systematic tendencies that may hinder their ability to render an impartial decision. The question, therefore, is whether these various biases are strong enough to warrant disqualification.

The determination of the proper trier of fact will depend on the commitment goal that the state has chosen. But regardless of the goal sought, the trier of fact should be independent of the hospital, and the selection narrowed to either an unaffiliated psychiatrist or a judge. The potential biases of internal review and the accompanying appearance of impropriety warrant going outside the hospital to find an arbiter.

42. See State ex rel. Fuller v. Mullinax, 364 Mo. 858, 866, 269 S.W.2d 7, 12 (1954) (hearing must be mandatory because of patients' general ignorance of rights).

43. See Kaimowitz v. Michigan Dep't of Mental Hygiene, No. 73-19434 AW (Cir. Ct. Wayne County, Mich. July 10, 1973), reprinted in A. Brooks, supra note 10, at 907, 911 (hospital atmosphere inherently coercive); Developments, supra note 3, at 1354 (patients may assume only way out of hospital is cooperation with staff).


45. Cf. E. Goffman, Asylums 51, 77 (1961) (patients can be educated about price they will pay for making demands on their own behalf with regard to legal rights).

46. See pp. 854-55 supra.


1. The Therapeutic Goal

The conflict between the two possible goals of civil commitment becomes apparent when one compares the biases of psychiatrists to those of judges. If the legal standard is designed to approach a medical one, such as “in need of treatment,” a doctor’s bias in favor of treatment and tendency to apply a medical standard will not adversely affect the desired goal. Because a psychiatric arbiter is trained to diagnose and treat mental illness, he appears best qualified to appraise the evidence bearing on a patient’s need for treatment. A nonmedical arbiter who receives psychiatric testimony will have little knowledge with which to evaluate the credibility of the witness. A layman may also over-emphasize the patient’s eccentricity in determining the need for hospitalization.

neutral adjudicator outside parole board). Internal review necessarily involves a prior judgment analogous to that in Nilva v. United States, 352 U.S. 385 (1957), because the hospital has already made an initial decision not to release the patient. In addition, internal review establishes the moving party, i.e., the hospital, as arbiter. This is arguably a closer association than was present in Berkshire Employees Ass’n v. NLRB, 121 F.2d 235 (3d Cir. 1941) (participant in labor dispute). Finally, the state also has an interest in preserving a sense of propriety when choosing a trier of fact. Propriety depends on appearance and on the potential harm that bias can cause, rather than on proven harm.

There may be two interests in providing only hospital review. The patient’s own psychiatrist might be chosen because he is most familiar with the patient’s illness. See M. GUTTMACHER & H. WEINHOFEN, PSYCHIATRY AND THE LAW 302 (1952). But the state hospital psychiatrist may have little contact with his patients, and the time required for another psychiatrist to achieve an equal familiarity would consequently be minimal. See N. KITTRIE, THE RIGHT TO BE DIFFERENT 98 (1971); R. ROCK, supra note 30, at 55, 69-71; A. STRAUSS, supra note 17, at 95-96, 125 (little psychiatric attention to chronic wards). Consequently, the problems caused by inherent biases, see p. 854 supra, outweigh the usefulness of the patient’s own psychiatrist.

Choosing a hospital-affiliated psychiatrist might promote more effective treatment since a patient may be more cooperative if he knows that only the hospital can release him. But the patient may not be aware of a right to periodic review, see p. 858 supra, and periodic review would probably not be so frequent that it would be practical for the patient to wait for a new hearing rather than cooperate with the hospital staff.

Moreover, since the patient still may petition for a writ of habeas corpus, see Developments, supra note 3, at 138 & n.22 (listing habeas statutes for 50 states and District of Columbia), the additional outlet of periodic review should not seriously alter the patient’s perception of the degree of cooperation necessary to leave the hospital.

49. Ideally, the legal standard would be only a subcategory of a medical one, and would explicitly be narrowed to encompass an individual’s need for treatment in a mental hospital. An evidentiary requirement that the hospital show that it is the least restrictive environment in which treatment can be administered would help accomplish this narrowing of standards. See pp. 866-67 infra (suggesting this requirement).

50. See R. ROCK, supra note 30, at 259-60 (lay arbiter cannot accurately evaluate need for treatment in mental hospital and patient’s prognosis, whereas psychiatric arbiter can). But see Bazelon, Institutionalization, Deinstitutionalization and the Adversary Process, 75 COLUM. L. REV. 897, 903-04 (1975) (judges have ability to evaluate expert testimony on need for treatment).

51. See R. ROCK, supra note 30, at 259-60. As a practical matter, nonmedical arbiters rely almost exclusively on psychiatric opinion when medical questions are in issue. See p. 855 supra.

52. See p. 855 supra.
Finally, although a medical arbiter will suffer from a treatment bias and is likely to give less weight to the patient's liberty interest than would a judge,\textsuperscript{53} this is not a serious problem in periodic review because the state has already had some opportunity to treat the patient and psychiatrists regard prolonged hospitalization as antitherapeutic.\textsuperscript{54}

2. The Preventive Detention Goal

If the legal standard is dangerousness, a physician's tendency to commit all those who need treatment will defeat the chosen state goal. Although it would be inconsistent with medical ethics for a psychiatrist to violate the law,\textsuperscript{55} the physician will tend, as a practical matter, to disregard a dangerousness standard.\textsuperscript{56}

Moreover, psychiatrists have no special ability to diagnose dangerousness.\textsuperscript{57} Judges, on the other hand, are experienced in deciding mixed ethical, legal, social, and medical questions that arise under a dangerousness standard.\textsuperscript{58} A judge can weigh the seriousness of the patient's alleged dangerous acts\textsuperscript{59} along with the likelihood that the patient will repeat those acts. This process is similar to and draws from a

\textsuperscript{53} See pp. 854, 856 supra.

A psychiatric arbiter may also be reluctant—either from fear of tort liability or from a sense of medical ethics—to release a patient who is thought to be dangerous, independent of the patient's need for treatment. See pp. 854, 856 supra. The tort problem can be cured by giving the arbiter judicial immunity for his quasi-judicial acts. Although the "ethical" bias still remains, it should not have a significant effect on the vast majority of recommitment decisions because the mentally ill, as a societal class, are not dangerous. See B. Ennis & R. Emery, supra note 21, at 45.

Consequently the special expertise required for "treatment" hearings, see note 25 supra, outweighs the possible detriment from the inherent biases of psychiatric arbiters. It is more questionable, however, whether choosing a psychiatric arbiter for initial commitment would result in a satisfactory balancing of expertise against biases that may impinge on a patient's liberty interest. But see S. Braekel & R. Rock, The Mentally Disabled and the Law 59-60 (rev. ed. 1971) (American Psychiatric Association recommends that commitment be left entirely to psychiatrists).

\textsuperscript{55} See Opinions and Report, supra note 18, § 4, at 23 ("[P]hysicians should observe all laws . . . .")
\textsuperscript{56} See p. 854 supra.
\textsuperscript{57} See A. Stone, supra note 19, at 25-40 (studies show psychiatrists unable to predict better than laymen, and-more likely to overpredict); Livermore, Malmquist & McEehl, On the Justifications for Civil Commitment, 117 U. Pa. L. Rev. 75, 85 & n.29 (1969) (psychiatrists have no special ability to predict dangerousness).
\textsuperscript{58} See B. Ennis & R. Emery, supra note 21, at 66; Bazelon, supra note 50.
\textsuperscript{59} See pp. 865-66 infra (crucial issue in dangerousness commitment hearings should be dangerous acts of patient).
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judge's considerable experience in sentencing. A doctor's expertise is unrelated to such inquiries.

In sum, the choice of a trier of fact depends on which of the two basic civil commitment goals a state has selected. Under a therapeutic goal the optimal arbiter is the unaffiliated psychiatrist. Under a preventive detention standard, a trained judge is preferable.

C. Allocation of the Proof Burden

It is also important to focus on the civil commitment goals in deciding who should bear the burden of proof and what the standard of proof should be. Proper allocation of the proof burden will serve both to affirm societal value judgments and to correct inherent flaws in the proceeding that favor the state.

1. Societal Value Judgments

The allocation of a heavy burden of proof to the state in periodic review affirms a societal value judgment regarding involuntary hospitalization that results from balancing the state's interest against the individual's. The most analogous state proceeding in which physical liberty is at stake is the criminal trial. The decision to require the

60. The relevant inquiries in sentencing involve, inter alia, the likelihood of the criminal's engaging in further criminal activity and the criminal's rehabilitation. Research suggests that rehabilitation, like dangerousness, cannot be observed, detected, or measured. See Project, Parole Release Decisionmaking and the Sentencing Process, 84 YALE L.J. 810, 826, 855 (1975).

61. See B. Ennis & R. Emery, supra note 21, at 66 (doctors, unlike judges, not trained in impartial adjudication, taking evidence or protecting legal rights); R. Rock, supra note 30, at 260 (doctors accustomed to dealing from position of authority in doctor-patient relationship and likely to substitute administrative convenience for patient welfare).

62. When both goals are employed, and the patient can be committed under either standard, see note 7 supra, two hearings will be required since "dangerousness" and "in need of treatment" are not complete subsets of each other. The dangerousness hearing should be conducted first so that there is less chance that the psychiatrist in the corresponding "treatment" hearing will feel compelled to make a dangerousness judgment. See note 54 supra (possibility of physician trying to hospitalize nontreatable dangerous patients).

63. See, e.g., In re Winship, 397 U.S. 358, 365-68 (1970) (approving such analysis in criminal context); James, Burdens of Proof, 47 VA. L. REV. 51, 60 (1961) (allocation in civil suits should depend on access to knowledge, extent that party's contentions depart from ordinary experience, and other policy judgments); Underwood, The Thumb on the Scales of Justice: Burdens of Persuasion in Criminal Cases, 86 YALE L.J. 1299, 1306-08 (1977) (approving such analysis). Burden of proof of a fact is discharged when the trier of fact has been persuaded by sufficient evidence of the truth of the fact to be proved. McCormick's HANDBOOK OF THE LAW OF EVIDENCE § 336 (E. Cleary 2d ed. 1972); cf. Texas v. Addington, 557 S.W.2d 511 (Tex. 1977), prob. juris. noted, 435 U.S. 967 (1978) (Supreme Court may address burden-of-proof issue in initial commitment).

64. Although the parole process also involves a liberty interest, it is distinct from the interests involved in either the civil commitment process or the criminal trial. A person
state to prove guilt beyond a reasonable doubt reflects a judgment that it is better to allow a guilty defendant to go free than to convict an innocent one. The deprivation of liberty suffered by committed patients is largely the same as that suffered by convicted criminals. In addition, although civil commitment is not intended to carry the opprobrium that normally attaches to criminal conviction, it carries its own equally damaging stigmatic effect.

The state's interest in preventing the release of patients who should be committed depends on the commitment goal or goals that the state has selected. Society may suffer harm from the release of a truly dangerous patient. Yet identifiable classes of criminal defendants, such as repeat offenders, present a similar danger, and the criminal value judgment still demands that the state bear the burden of proof beyond a reasonable doubt. It is therefore appropriate that the state bear the burden of proof in civil commitment. That burden, moreover, should
go through the parole process has only a conditional liberty interest, because the societal value judgments that deprived him of his liberty for a fixed period of time have already been made. At the time of the parole hearing—a point at which the society voluntarily undertakes to reexamine its judgments—the individual's liberty interest has changed. But society's interests, which include general deterrence and retribution, remain the same.

Societal interests in detaining a person alleged to be mentally ill cease when the purpose for the detention no longer exists. The society's interests do not include retribution and deterrence, because there is nothing to punish and in many cases nothing that can be deterred. In criminal trials individual liberty interests are preserved by the presumption of innocence until the verdict is rendered. Society's interest in retribution comes into play only after an individual has been convicted of a crime. Thus the civil commitment process, in terms of the societal interests involved, is much closer to the initial trial than to the parole stage of the criminal process.

The only civil case in which a party, whose physical liberty is at stake, must bear the burden of proof is in a habeas corpus hearing. Such a quasi-appellate hearing is not analogous to periodic review because periodic review is concerned with current status rather than the propriety of initial confinement. See Developments, supra note 3, at 1386.


S. Commentators believe that former mental patients are generally feared, loathed, or distrusted. See, e.g., B. Ennis, Prisoners of Psychiatry—Mental Patients, Psychiatrists, and the Law 160-76 (1972) (citing examples of discrimination).

A commonly offered but meritless distinction between imprisonment and civil commitment is that falsely committed nondangerous patients may still receive benefit through treatment. See Developments, supra note 3, at 1231-35. If the patient's illness cannot be treated—or if there is no illness to treat—the patient receives no benefit. Moreover dangerousness is not treatable per se. Thus when the symptoms disappear, there is no guarantee that the patient will no longer be dangerous and in need of confinement. See note 57 supra (citing studies); B. Ennis & R. Emery, supra note 21, at 47 (no ability to treat); A. Stone, supra note 19, at 36-37 (same). In fact, under a dangerousness standard the state may not even be required to provide treatment. See O'Connor v. Donaldson, 422 U.S. 563, 574 (1975). Thus treatment does not compensate for deprivation of liberty, and is poor consolation for false commitment.
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be to prove dangerousness beyond a reasonable doubt.\textsuperscript{67} Even when a defendant has a history of violent crime, the Constitution requires that the state bear such a heavy burden.\textsuperscript{68} The potential harm to society from releasing the dangerous mentally ill is no greater than from releasing dangerous criminals.\textsuperscript{69}

Finally, it would not make sense to lower the burden of proof when the therapeutic standard is employed. The deprivation of liberty under a therapeutic standard is identical to that under a preventive detention standard, but the potential societal harm of releasing those who need treatment is much lower.\textsuperscript{70} Thus societal value judgments under both standards demand that the state bear a very heavy burden of proof to continue hospitalizing a civilly committed patient.

2. Additional Considerations in Cases Decided Under the Dangerousness Standard

In the case of patients committed under a dangerousness standard, there are additional reasons to put the burden of proof on the state. These reasons all stem from the need to compensate for the flaws in the commitment process that favor the state.

When dangerousness is at issue, the patient’s disabled condition may


\textsuperscript{68} See, e.g., \textit{Estelle v. Williams,} 425 U.S. 501, 502-03 (1975) (guilt must be proven beyond reasonable doubt for alleged assault with intent to commit murder with malice when defendant “struck landlord with knife in neck, chest, and abdomen, severely wounding him”); \textit{In re Winship,} 397 U.S. 358, 364 (1970) (guilt must be established beyond reasonable doubt in all criminal trials).

\textsuperscript{69} There may be even greater harm in releasing dangerous criminals than in releasing dangerous mental patients. One function of criminal law is its deterrent effect. Acquitting a larger segment of guilty defendants by requiring that the state bear a heavy burden of proof undermines to some extent this deterrent effect. Commitment may not have a similar deterrent effect because some dangerous mentally ill do not have sufficient control over their actions to alter them in order to avoid risking commitment. Thus, requiring that the state bear a heavy burden would not significantly undermine any deterrent effect.

\textsuperscript{70} The commonly offered rationale for not releasing patients in need of treatment is potential harm to the individual patient rather than to society. \textit{See, e.g., M. GUTTMACHER & H. WEHOFEN, supra note} 48, at 288-92; \textit{Developments, supra note} 3, at 1223-25. Perhaps continued confinement results not from a belief in dangerousness or need for treatment, but from a desire to grant friends, relatives, and neighbors relief from the nuisance of having to care for and deal with the patient. \textit{See E. GOFFMAN, supra note} 45, at 384. But harm to the patient or nuisance to caretakers should be seen as less serious than dangerous acts against other persons in determining the weight of the state interest in confinement.

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complicate his ability to give testimony and may prejudice the trier of fact. Yet the patient's testimony is necessary since weight will be given to his past dangerous acts. The patient must be able to rebut adverse testimony by claiming that the acts never took place or by explaining why they were not dangerous.

Second, the hospital has a much greater opportunity to develop a record. Because it knows that litigation is possible, the hospital staff may depict the patient's condition inaccurately. Moreover, making an accurate determination of dangerousness requires reports on behavior that span several weeks. Thus in most cases it will be impractical for the arbiter himself to amass an adequate record.

Third, allocating the burden of proof to the patient could elevate the vagueness problems of a dangerousness standard to unconstitutional proportions. The Supreme Court has employed the void-for-vagueness doctrine to invalidate statutes that establish nonjusticiable standards or that chill fundamental rights by failing to give adequate

71. See p. 855 supra.
72. See Developments, supra note 3, at 1282.
74. One important factor in allocating the burden of proof is determining which party has better access to and control over the evidence. See James, supra note 63, at 60. Considerations of control over records also apply to cases in which a treatment standard is used, but are less important there because the record is less likely to be exaggerated or falsified if the hospital staff believes that treatment will be provided if needed. Such a belief is more likely to exist when the arbiter is a psychiatrist rather than a judge.

Regardless of the allocation of the burden of proof, the patient and his counsel should have complete access to all materials in the hospital record in order to build a proper case. There may be instances in which a hospital has bona fide treatment-related reasons for not wishing a patient to see all of his own files. But at the very least, that judgment should be made by the arbiter rather than by an interested party.
75. See pp. 855-56 supra.
77. In Speiser v. Randall, 357 U.S. 513 (1958), the Court held that a burden of proof that forced a plaintiff to demonstrate that his speech was not "subversive" unconstitutionally chilled free expression. Similarly, requiring the patient to prove that his conduct is not "dangerous" may impermissibly chill the patient's constitutional interest in liberty by forcing him to restrict his speech and conduct greatly.
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notice of what constitutes proscribed conduct. Putting the burden of proof on the patient might do both. Predictions of dangerousness, when made without the benefit of any recent overt act, are not justiciable because they usually are statistically unreliable. Fundamental rights of speech, movement, and association might be chilled because the patient would not know which actions might trigger preventive detention. Thus the need to offset these inherent flaws in dangerousness cases provides an independent ground for placing a heavy burden of proof on the state in these periodic review hearings.

D. Evidentiary Standards

Choosing the optimal trier of fact and allocating the burden of proof correctly, however, are not sufficient to cure all the defects inherent in periodic review. Substantive evidentiary rules must also be properly structured.

1. The Overt Act Rule

Under a preventive detention standard, it is uncertain what evidence should be required for a finding of dangerousness. The best available test would require that dangerousness be evidenced by a recent overt act. The overt act should be one that reasonably could be expected to cause physical harm to a person. Both the recentness and the

79. See p. 856 supra.
80. Confinement could rest on a determination of mental illness alone, because, in the absence of an overt act requirement, there would be no way to disprove dangerousness. See pp. 856-57 supra. Consequently, conduct and speech unrelated to dangerous activity might be chilled because the potential patient would have no way of knowing which assortment of actions and speech might be deemed symptoms of dangerousness.
The result would be even worse if the burden of proof were applied conscientiously. Because no patient can affirmatively show that he is not dangerous without an overt act rule, the arbiter would always hospitalize the patient.
81. See pp. 856-57 supra.
82. See Developments, supra note 3, at 1205-06. But see Note, supra note 35, at 589 (suggesting other tests that might cure vagueness problems).
83. The overt act requirement should not be satisfied by a showing of repulsion, annoyance, or threatened property damage unless the threat could reasonably be expected to extend also to physical injury to persons. See Suzuki v. Alba, 438 F. Supp. 1106, 1109 (D. Hawaii 1977).
In addition, there should be a presumption against continuing confinement. Most acts that occurred prior to initial commitment should not on periodic review be sufficient to warrant further hospitalization unless those acts were gravely injurious. Hospital incidents
gravity of the act committed should be considered. In addition, the state ought to have the burden of pleading and proving the overt act beyond a reasonable doubt. Finally, because a lay arbiter will tend to rely heavily on medical opinion, psychiatric conclusions as to dangerousness, even if based on recent overt acts, should be inadmissible.

Such an overt act rule would ameliorate the defects in the commitment proceeding. The prejudicial effect of a patient's unconventional appearance may be lessened by explicitly restricting the court's inquiry to the occurrence of dangerous acts. Requiring the state to produce evidence of dangerousness would limit the degree to which a hospital's exaggeration of incidents could affect the outcome of a case. Because a patently dangerous incident is likely to be easily recognized, a report of it would tend to be more reliable than would reports of bizarre or uncooperative behavior. Furthermore, such a rule would avoid substantial vagueness problems. Acts likely to cause or precede harm to life constitute a fairly understandable category that gives fair notice to committed patients.

2. The Least-Restrictive-Means Rule

Another evidentiary standard that should be adopted by states is a least-restrictive-means rule. This rule would require the state to prove that the hospital is the least physically restrictive placement necessary for either treatment or preventive detention, and to investigate and report all reasonable alternative placements to the arbiter. Possible placements might include the patient's home, the homes of friends or relatives, halfway houses, or nursing homes. The report should also indicate why such alternatives were inappropriate.

The least-restrictive-means rule would narrow the scope of the "in need of treatment" standard by limiting it to treatment that only a hospital can provide. Often patients need treatment in some structured

should be the dominant factor in recommitment decisions. The hospital by its nature may either inhibit harmful activity or, by frustrating the patient, provoke him to violence. Thus the arbiter must weigh the circumstances under which the violent acts occurred in deciding their probative value.

84. See pp. 861-65 supra.
85. See p. 855 supra.
86. Although this would not counteract any intentional bias, it would put the arbiter on notice that he must not base his findings solely on the patient's appearance.
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environment but do not require the constant supervision provided in a mental hospital. The state should bear the burden of proof because it usually has the best knowledge of the facilities available and should, as a matter of policy, be encouraged to search out alternative placements for its patients.

Conclusion

The Connecticut Supreme Court's decision in Fasulo v. Arafeh that periodic review for civilly committed mental patients is constitutionally mandated presents a challenge to all legislatures to provide procedural safeguards that ensure that periodic review comports with the requirements of due process. This Note has suggested some of the practical and constitutional factors that both the legislature and the judiciary should consider in implementing such periodic review safeguards.

89. See Crane, Zonana & Wizner, supra note 3, at 832-33 (study shows significant number of long-term hospital patients suitable for less restrictive placement).
90. See id. (hospital should assume more active role in review and discharge planning).