Theorizing Disability Discrimination in Civil Commitment*

I. Introduction

The Supreme Court has described involuntary commitment as “a massive curtailment of liberty.” Commitment infringes a host of fundamental rights—“the right to liberty, to freedom of association, . . . to freedom from unreasonable searches and seizures,” to privacy, to keep and bear arms, and in some cases to vote—and confines people who have committed no crime. It entails a profound loss of personal autonomy—even including the precious right to be let alone. People who are committed are separated from their family, friends, and community—“held under lock and key”—and made to lead a life they did not choose.

But commitment also imposes less tangible burdens, many of which persist long after a person’s release. The stigma associated with commitment is significant and may serve not only as a source of embarrassment and shame but also as a serious impediment to obtaining future employment, housing, and education. Hurdles in these areas often arise unexpectedly, years after

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3. Typically, commitment permanently strips a person of her Second Amendment rights. See 18 U.S.C. § 922(g)(4) (2012) (“It shall be unlawful for any person . . . who has been committed to a mental institution . . . [to] possess . . . any firearm or ammunition . . . which has been shipped or transported in interstate or foreign commerce.”). But see Tyler v. Hillsdale Cnty. Sheriff’s Dep’t, 775 F.3d 308, 311, 344 (6th Cir. 2014) (applying strict scrutiny to strike down the state’s application of § 922(g)(4) to a presently “non-dangerous” and “mentally healthy” man who was committed to a mental institution for less than a month 28 years prior in the wake of an “emotionally devastating divorce”).

4. See Sally Balch Hurme & Paul S. Applebaum, Defining and Assessing Capacity to Vote: The Effect of Mental Impairment on the Rights of Voters, 38 McGeorge L. Rev. 931, 936–46 (2007) (analyzing state voting rights laws and concluding that in some states “the right to vote may be determined . . . in a civil commitment proceeding”).

5. LEVY & RUBENSTEIN, supra note 2, at 15.

6. See Olmstead v. United States, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) (describing “the right to be let alone” as “the most comprehensive of rights and the right most valued by civilized men”).

7. LEVY & RUBENSTEIN, supra note 2, at 15.

a commitment has ended, frustrating efforts to leave the past behind.  
Prejudice against people with mental illness pervades our social institutions, including our mental-health system. Mental-health professionals are susceptible to the same prejudices about people with mental illness as society at large, and when these prejudices inform decisions about diagnosis and treatment—including involuntary commitment—people with mental illness (and people mistakenly regarded as having mental illness) suffer harmful discrimination and violations of their civil rights.

But what does discrimination in the context of involuntary commitment look like? And how might the law provide a remedy? This Note attempts to answer both questions. Part II situates involuntary commitment in its historical context and describes the standards and practices that characterize it today. Part III explores how and why stereotypes about mental illness can influence commitment decisions. Part IV sets out a two-pronged theory of discriminatory commitment that focuses on two phases of the commitment process: the decision phase, in which it is decided that a person meets the standards for involuntary commitment, and the provision phase, in which the treatment service—the commitment—is provided or carried out. As to the first phase (the decision phase), I argue that commitment is discriminatory when the commitment decision is based on prejudice or stereotypes about people with mental illness, and I address the thorny question of how to identify such decisions. I refer to discrimination that occurs in this phase of the commitment process as “discriminatory-decision.” As to the second phase (the provision phase), I argue that commitment is discriminatory when its provision—that is, its administration—fails to reasonably accommodate the committed person’s disability. I refer to this kind of discrimination as

MGBL (identifying discrimination arising from the stigma of mental illness as a significant barrier to securing health care, employment, and housing).


10. See, e.g., ELYN R. SAKS, THE CENTER CANNOT HOLD: MY JOURNEY THROUGH MADNESS 232 (2007) (“Stigma against mental illness is a scourge with many faces, and the medical community wears a number of those faces.”); id. at 331 (naming among the “myths held by many mental-health professionals themselves—that people with a significant thought disorder cannot live independently, cannot work at challenging jobs, cannot have true friendships, cannot be in meaningful, sexually satisfying love relationships, cannot lead lives of intellectual, spiritual, or emotional richness”). Elyn Saks carries a diagnosis of schizophrenia. Id. at 167. She is a former Marshall Scholar and is currently the Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences at the University of Southern California Gould School of Law and an adjunct professor at the University of California, San Diego School of Medicine. Elyn Saks, USC GOULD SCH. L., http://weblaw.usc.edu/contact/contactinfo.cfm?detailID=300, archived at http://perma.cc/4QY9-H2LN.

11. I use this term loosely to refer to psychiatrists and other physicians, psychologists, clinical social workers, counselors, and others who may provide mental-health services.
“discriminatory-provision.” I examine each kind of discrimination with the help of a case study that illustrates how it manifests and, I hope, why its victims deserve a remedy. Part V concludes.

The theory of discriminatory commitment elaborated here has several advantages. First, it posits a viable remedy under existing federal law because it tracks the language of the Americans with Disabilities Act (ADA). It requires no legislative action—only an interpretation of the ADA already embraced by some courts. This is not to say, of course, that this theory of discriminatory commitment is incompatible with legislative reform. It is not. At turns, I point out specific reforms that would likely aid the theory’s implementation. For example, I argue that the baseline standard for commitment common to all of the states—the so-called “dangerousness standard”—should include the requirement of proof of a recent, overt act showing dangerousness. This requirement would give teeth to existing laws, which, as discussed in Part IV, are routinely flouted by mental-health professionals and by courts. I also argue that states should furnish independent psychiatrists to serve as expert witnesses for proposed patients who are indigent and cannot afford an expert. When there is room (as often there is) for psychiatrists to reach different conclusions about whether a proposed patient meets the legal standard for commitment, courts would benefit from a broader range of psychiatric opinions. In particular, courts would benefit from the opinions of psychiatrists who do not work for the state and who did not help initiate the commitment process in the first place.

Lurking in the background of this Note is the question of whether all commitment is discriminatory—that is, whether commitment is itself discrimination against people with mental illness. A theory of discriminatory commitment that answered this question in the affirmative may indeed answer it correctly as an intellectual matter, but such a theory would be neither original nor presently very useful, as society considered and rejected abolitionist arguments decades ago and has not seen fit to revisit them. Indeed, society is unwilling in many instances even to enforce the reforms it enacted at that time. The theory of discriminatory commitment developed

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13. E.g., Bolmer v. Oliveira, 594 F.3d 134, 146 (2d Cir. 2010).
14. As a matter of due process, an overt act would require proof satisfying at least the “clear and convincing” standard. See infra note 78 and accompanying text.
15. For an excellent article arguing that constitutional due process entitles indigent proposed patients to evaluation by an impartial psychiatrist, see Scott F. Uhler, The Constitutional Right of the Indigent Facing Involuntary Civil Commitment to an Independent Psychiatric Examination, 20 AKRON L. REV. 71 (1986). In part because Uhler’s doctrinal analysis is so thorough, I focus on the wisdom of independent psychiatric evaluations from a policy perspective.
16. See, e.g., THOMAS SZASZ, PSYCHIATRIC SLAVERY 9 (1977) (arguing for the abolition of involuntary commitment and analogizing it to chattel slavery).
17. See infra notes 74–76 and accompanying text.
here points to grave problems with commitment as it is now practiced, but this Note is ultimately an argument for reform not abolition.

Implicit in this argument for reform is the idea that commitment is a legal institution worth retaining. Commitment serves a valuable function for people whose alternative is incarceration. When a person is truly dangerous—when she attacks others, for example, because of hallucinations or delusions caused by mental illness—it is only a matter of time before she enters the criminal justice system. As a philosophical matter, this is a wrong outcome because the legitimacy of the criminal justice system depends on the moral culpability of the offender. We punish offenders not only to deter future crimes but also on the belief that they deserve punishment. But punishing people who commit crimes because of serious mental illness may serve virtually no deterrent or desert function at all. Further, as a practical matter, the shunting of people with mental illness into the criminal justice system is a wrong outcome because the principal punishment that the criminal justice system metes out—incarceration—in many cases only aggravates mental illness. This is both cruel and counterproductive. For


   For hundreds of years the books have repeated with unbroken cadence that Actus non facit reum nisi mens sit rea. There can be no crime, large or small, without an evil mind . . . . It is therefore a principle of our legal system . . . that the essence of an offence is the wrongful intent, without which it cannot exist.

   Sayre, supra (citation omitted) (quoting John M. Zane & Carl Zollmann eds., 9th ed. 1923) (internal quotation marks omitted).


20. See Herbert Morris, Persons and Punishment, 52 MONIST 475, 478–79 (1968), reprinted in Dressler, supra note 19, at 43, 44 (“Sometimes [the rules] provide a defense if . . . a person lacked the capacity to conform his conduct to the rules. Thus, someone who in an epileptic seizure strikes another is excused. Punishment in these cases would be punishment of the innocent . . . .”).


these reasons, a basic premise of this Note is that commitment’s existence as a legal institution is justified on both normative and utilitarian grounds. The question, then, is the proper character of that institution and the reforms needed to ensure its fairness. This is the question taken up here.

II. The Evolution of Commitment in Theory and Practice

A. Brief History of Commitment in the United States

The American “asylum” emerged in the United States as an institution distinct from the general hospital “in the second quarter of the nineteenth century.”23 The term “asylum,” which reflected the intention that it serve as a refuge for patients “from the stresses of the outside world,”24 speaks both to its original humanitarian purpose and deep paternalism. From the beginning, it was presumed that most patients would be admitted involuntarily on the rationale that mental illness vitiated, if not destroyed, the capacity to seek and consent to treatment.25 Early asylums housed not only people with mental illness but also myriad other “undesirables,” including immigrants and the poor.26 Initially, the only requirement for commitment was that a person “need” or be “likely to benefit from treatment.”27 This permissive standard, coupled with an absence of procedural safeguards, ensured that physicians initially exercised almost exclusive control over commitment decisions.28 After the Civil War, however, publicity about abuses—perhaps the most sensational of which involved collusion between a physician and his patient’s family to commit the patient so they could embezzle her fortune29—and squalid conditions in asylums prompted

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24. Id. at 19.
25. Id. at 20.
26. LEVY & RUBENSTEIN, supra note 2, at 18 (quoting DAVID J. ROTHMAN, DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC 286 (1971)).
27. APPELBAUM, supra note 23, at 20.
28. Cf. id. (stating that admission to asylums was “essentially left in the hands of family members and physicians”).
29. See, e.g., APPELBAUM, supra note 23, at 20 (“Following the Civil War, allegations began to be heard that persons had been railroaded into mental institutions by greedy relatives and conniving physicians.”). Such abuses continue today: In Musko v. McClandom, a local official responsible for enforcing housing ordinances conspired with a psychiatrist to commit the official’s neighbor (a repeat violator of housing ordinances), whose innovations in domestic design the judge described in colorful detail:

He has placed signs and other “communicative materials” outside his home, and . . . expressed unorthodox views about decorating the exterior of his home, such as placing blinds not on the inside of his windows, which seems to be the normal practice, but on the outside, where they can better shade the entire window, and perhaps protect it from the elements. Indeed, it would appear that he is pressing domestic design expression to its utter outer limits. “Fallingwater” he leaves in his wake. He alleges that his unorthodox expression motivated defendants to retaliate against him [by conspiring successfully to commit him].
reform.\textsuperscript{30} In some places, this reform included the adoption of jury trials to improve the integrity of commitment proceedings and to imbue them with a measure of the layperson’s common sense.\textsuperscript{31} Still, reformers succeeded only in adding procedural safeguards, and even those proved impermanent.\textsuperscript{32}

Over the next century, the rigor of commitment procedures oscillated as states sought to balance the need for expedition in the commitment process with concerns about the protection of civil liberties.\textsuperscript{33} For the most part, though, commitment received little critical attention, in part because of the convenience of simply confining people.\textsuperscript{34} The substantive standards for commitment did not change during this period and required only a “need for treatment,” so physicians continued to dominate the commitment process.\textsuperscript{35} The need for treatment standard remained in place until the mid-twentieth century when a wave of public interest in the civil rights of people with disabilities produced a sea change in the laws of commitment.\textsuperscript{36} Until the reforms came, however, institutions continued to swell in size and in number, undergoing a “massive expansion” at the turn of the twentieth century that coincided with increasing urbanization and immigration.\textsuperscript{37} The expansion of institutions during this period was driven in part by disciples of the eugenics movement “who saw people with disabilities as a threat to the social order.”\textsuperscript{38}

In 1902, Dr. Walter Fernald, one-time eugenicist and a leader of the Association of Medical Officers of American Institutions for Idiotic and Feeble-Minded Persons, asked pointedly: “What is to be done with the feeble-minded progeny of the foreign hordes that have settled and are settling..."
among us?" As noted scholar Fred Pelka explains, "[b]y the mid-twentieth century the institutional system had grown into an insular and extensive disability gulag" that employed tens of thousands of staff represented by powerful unions that “actively impeded” the development of less restrictive, community-based treatment alternatives.40

Reform of civil commitment laws did not happen quickly or in a vacuum. Rather, it happened as part of a much larger project of reform by the disability-rights movement, which sought (broadly) to redefine the nature of disability and to ensure that people with disabilities could participate fully in society’s institutions on their own terms and without the fetters of stigma and discrimination.41 In addition to spurring reform of state laws on involuntary commitment,42 the disability-rights movement also made possible the passage of federal reforms, including the Rehabilitation Act of

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39. Id. at 49 (quoting 56TH ANNUAL REPORT OF THE TRUSTEES OF THE MASSACHUSETTS SCHOOL FOR THE FEEBLE-MINDED AT WALTHAM, FOR THE YEAR ENDING SEPTEMBER 30, 1903, at 14 (1904)). Fernald later changed his tune. His views on institutionalization flipped after he conducted a study in which formerly institutionalized persons with developmental disabilities fared much better in community settings than expected. See Walter E. Fernald, After-Care Study of the Patients Discharged from Waverly for a Period of Twenty-Five Years, 5 UNGRADED 25, 26, 31 (1919) (presenting evidence that contrary to his assumption “that nearly all of these people [with developmental disabilities] should remain in the institution indefinitely,” many could in fact lead productive lives in the community). He later served as an early advocate in the disability-rights movement. See Leadership in the History of the Developmental Disabilities Movement: Walter Fernald, DISABILITY HIST. PROJECT, http://www.disabilityhistorywiki.org/leadership/presentation page.asp?presentation=4, archived at http://perma.cc/T5EG-LAT5 (describing the impact of Fernald’s after-care study on his views on institutionalization).

40. PELKA, supra note 37, at 49.

41. Lauren E. Jones, The Framing of Fat: Narratives of Health and Disability in Fat Discrimination Litigation, 87 N.Y.U. L. REV. 1996, 2013 (2012) (describing the modern disability-rights movement as seeking “access, deinstitutionalization, an end to discrimination, and a mainstream understanding of disability that no longer views disabled people as inferior to nondisabled people”). In an article on the deinstitutionalization movement, Professor Samuel Bagenstos offered the following account:

[T]he disability rights movement started with the observation that people with disabilities share a common experience of systematic exclusion, but it took the point a step further. It added the insight that the very notion of “disability” depends crucially on the social practices that create that shared experience. To most disability rights advocates, “disability” is not an inherent trait of the “disabled” person. Rather, it is a condition that results from the interaction between some physical or mental characteristic labeled an “impairment” and the contingent decisions that have made physical and social structures inaccessible to people with that condition. The proper remedy for disability-based disadvantage, in this view, is civil rights legislation to eliminate the attitudes and practices that exclude people with actual, past, or perceived impairments from opportunities to participate in public and private life.


42. See FAILER, supra note 33, at 80–83 (explaining how disability advocates’ shift to “rightstalk” led courts and legislatures to “rethink” involuntary hospitalization and “require more stringent standards for civil commitment”).
1973,\textsuperscript{43} the Education for All Handicapped Children Act of 1975,\textsuperscript{44} and later the Americans with Disabilities Act of 1990,\textsuperscript{45} among others.\textsuperscript{46}

Most commentators trace the beginnings of the contemporary disability-rights movement to the 1970s,\textsuperscript{47} when a remarkably diverse coalition coalesced behind the banner of disability rights. According to Samuel Bagenstos, a leading authority on disability antidiscrimination law, “[t]he frame of ‘independent living’ offered a means of aiding the effort to forge a collective identity of people with disabilities” because it “promised to resonate with a broad group of people with a wide range of conditions”:

[W]heelchair users . . . were not the only ones who sought independence from medical and other professionals who attempted to run their lives. Blind activists . . . also sought to escape dependence on rehabilitation professionals and charities that controlled and limited their opportunities. People with mental retardation, confined to . . . institutions throughout the country, organized . . . to seek freedom from institutionalization and the constant control of institution staff. People with psychiatric disabilities, too, sought deinstitutionalization, and many sought the establishment of consumer-controlled alternatives to the physician-dominated mental health system. . . . Deaf [people] . . . sought to escape the control of professionals who thought they knew what was best (in this case, professionals who forced individuals with hearing impairments to struggle to speak orally and read lips, rather than permitting them to speak sign language). Although there were many differences among these groups, all sought to make their own decisions concerning their lives, with all the risks that would entail. All sought freedom from professionals and welfare bureaucracies that paternalistically made decisions for them. All sought self-reliance rather than dependence on the state or charity.\textsuperscript{48}

Given the shared experience of disabled people with the paternalism of the medical establishment, it is not surprising that so many rallied in support of deinstitutionalization. Perhaps a bit more surprising is that deinstitutionalization also resonated with conservatives who, faced with the “tight fiscal environment” wrought by stagflation in the 1970s, recognized an opportunity to rein in spending by closing large, expensive state

\textsuperscript{46} See Pelka, \textit{supra} note 37, at 28 (listing additional disability-rights legislation).  
\textsuperscript{47} James I. Charlton, Nothing About Us Without Us: Disability Oppression and Empowerment 130 (1998).  
institutions. Advocates of deinstitutionalization argued effectively that “people with psychiatric and developmental disabilities could be served just as well, and far more cheaply, in the community” at outpatient treatment centers. At the same time, the enactment of the Supplemental Security Income program in 1972, which “used federal funds to provide cash benefits to people with mental disabilities living in the community, further enabled states to shift costs off of their budgets by deinstitutionalizing.” Many commentators believe that “it was ultimately this coalition between civil liberties lawyers and fiscal conservatives that ensured that states would close and downsize their institutions.”

The deinstitutionalization project also benefited from the social consciousness of the times. The culture wars of the 1960s and 1970s saw a firestorm of criticism directed at the mental-health professions—in particular, psychiatry. Ironically, psychiatrists found themselves on the proverbial couch, subject to intense scrutiny by other professionals—perhaps most disagreeably by lawyers—and even by fellow psychiatrists. Among psychiatry’s most strident critics was the academic Thomas Szasz, himself a psychiatrist, who declared mental illness a social construct—a “myth” and decried commitment as “psychiatric slavery,” which like chattel slavery, he said, demanded abolition not reform. Szasz’s radical claims had rhetorical appeal but lacked a sound scientific basis. However, empirical

50. Id. at 20.
51. Id. at 21.
52. Id.
53. See Bruce J. Winick, Therapeutic Jurisprudence and the Civil Commitment Hearing, 10 J. CONTEMP. LEGAL ISSUES 37, 39 (1999) (observing that the media and civil rights lawyers during that period challenged institutionalization and the legitimacy of psychiatry).
54. Writing in the midst of these culture wars, the psychiatrist Michael Peszke summarized the typical attorney’s view of psychiatrists:

[In the commitment process, [the attorney] sees the physician—and specifically the psychiatrist—as usurping to himself those inherent rights which the constitution guarantees exclusively to the legal process. He sees that physician as being unwilling to become more open, as claiming all kinds of privileged status and as defending his monopoly at the expense of society.

MICHAEL ALFRED PESZKE, INVOLUNTARY TREATMENT OF THE MENTALLY ILL 135 (1975). Peszke had even harsher words for the legal academy, accusing it of exhibiting at times “a gross ignorance or even a conscious malevolence and dishonesty alien to worthy scholarship.” Id. (But maybe he was projecting.)

56. See SZASZ, supra note 16, at 9 (claiming that involuntary commitment “is an unjustifiable moral and legal wrong” that should be abandoned). Szasz’s claim that mental illness is a mere social construct can be understood as a radical echo of the disability-rights movement’s broader claim that disability is socially contingent—that is, “result[ing] [from] an interaction between biological restrictions and the broader physical and social environment.” Bagenstos, supra note 41, at 431.
57. See, e.g., Bruce C. Poulsen, Revisiting the Myth of Mental Illness: Some Thoughts on Thomas Szasz, REALITY PLAY, PSYCHOL. TODAY (Sept. 17, 2012), https://www.psychologytoday.c
studies conducted at the time did raise genuine concerns about the scientific foundations of psychiatry and concluded that in many cases psychiatrists “were not relying on any body of scientific expertise to reach their conclusions” but rather were “expressing their personal biases as if they represented professional opinion.”58 Advocates of deinstitutionalization criticized commitment as psychiatrists’ “stock response” to “any personality deviation” or other characteristic “mentioned in any standard textbook of psychiatry.”59 In one study, healthy individuals whom researchers familiarized with psychiatric diagnostic criteria feigned mental illness and were admitted at twelve different hospitals “without question.”60 Thus, the paternalism of psychiatry, which apologists defended (obliviously) as necessary to rescue “a group of helpless people,”61 received widespread condemnation.

As a result of the public outcry over the unjustified warehousing of people with mental illness, the financial cost of institutionalization in the face of cheaper alternatives, and pharmacological advances that made outpatient care more attractive than ever, states undertook fundamental changes in the structure of their mental health-care systems.62 The Supreme Court, accepting arguments grounded in constitutional due process, tightened the standards for commitment and demanded that psychiatrists treat patients in the least restrictive available setting.63 Perhaps the most significant reform was the replacement of the need for treatment standard with the dangerousness standard—subject to minor variation among the states—requiring that a person who is committed pose a danger to himself or others.64 The mental-health system moved on a national scale from the institutional-based to the community-based treatment model, resulting over time in a reduction in the number of institutionalized people from the hundreds of thousands to almost the tens of thousands.65 The reforms also transferred, at least in theory, a significant amount of decision-making authority from the

58. APPELBAUM, supra note 23, at 9.
59. PESZKE, supra note 54, at 117.
60. APPELBAUM, supra note 23, at 9.
61. PESZKE, supra note 54, at 134.
62. LEVY & RUBENSTEIN, supra note 2, at 19.
63. See id. at 32–33 (summarizing the Court’s reliance on notions of due process when it declared that a state cannot constitutionally confine a nondangerous person who is capable of surviving on his own).
64. See id. at 26–30 (observing that most states have adopted stringent standards for involuntary commitment that require a subject to present a substantial likelihood of serious physical harm to himself or others).
65. Id. at 19. See generally ROBERT D. MILLER, INVOLUNTARY CIVIL COMMITMENT OF THE MENTALLY ILL IN THE POST-REFORM ERA 188–90 (1987) (showing the reduction in involuntary admissions across various states due to statutory changes).
medical profession to the legal profession. (Whether a person would benefit from treatment is a medical question, but whether she is dangerous is manifestly not.) Thus, whereas physicians until then had exercised almost complete discretion in commitment decisions, lawyers and judges came to play an increasingly important gatekeeping role.66

Unlike other civil rights movements of the era, the deinstitutionalization movement enjoyed broad bipartisan support67 because it spoke not only to the liberal conscience but also to the conservative ideal of less intrusive government. Despite this fact, deinstitutionalization—or at least the manner in which many states executed it—has been widely criticized in the intervening years. The most powerful ex post criticism of deinstitutionalization is that it caused an epidemic of homelessness among people with mental illness68—thus the evocative phrase “rotting with your rights on.”69

Indeed, there is strong evidence that homelessness increased in the wake of deinstitutionalization.70 However, there is also evidence that concurrent cuts to social welfare programs are best viewed as the proximate cause.71 The National Coalition for the Homeless (NCH) maintains that “[d]espite the disproportionate number of severely mentally ill people among the homeless population, increases in homelessness are not attributable to the release of severely mentally ill people from institutions.”72 Rather, the NCH says, a lack of access to supportive housing and community-based treatment are to blame.73 Moreover, deinstitutionalization has been more successful in some

66. See LEVY & RUBENSTEIN, supra note 2, at 20, 26–28 (describing the increased role of the courts in placing restrictions, such as the dangerousness standard, on commitments).


70. See Bagenstos, supra note 49, at 10 (“[H]omelessness rose as the population of state mental hospitals fell . . . .”); Martha R. Burt, Causes of the Growth of Homelessness During the 1980s, in UNDERSTANDING HOMELESSNESS: NEW POLICY AND RESEARCH PERSPECTIVES 169, 181 (Dennis P. Culhane & Steven P. Hornburg eds., 1997) (stating that the number of homeless people in the United States tripled in the 182 largest American cities over the course of the 1980s).

71. See Bagenstos, supra note 49, at 11 (suggesting that a “failure to invest in community-based services and supports” rather than deinstitutionalization is a leading cause of homelessness); cf. David Mechanic & David A. Rochefort, Deinstitutionalization: An Appraisal of Reform, 16 ANN. REV. SOC. 301, 317–18 (1990) (“There is little evidence to support the contention that deinstitutionalization is the primary cause of homelessness; it is one of many interacting causes.”).


73. Id. (citing SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., SMA-04-3870, BLUEPRINT FOR CHANGE: ENDING CHRONIC HOMELESSNESS FOR PERSONS WITH SERIOUS MENTAL ILLNESSES AND CO-OCCURRING SUBSTANCE USE DISORDERS (2003)).
places than in others,\textsuperscript{74} suggesting that the concept itself is not inherently flawed but that its success depends on the particulars of its implementation. Professor Bagenstos has argued persuasively that the shortcomings of deinstitutionalization resulted from the failure of the politically diverse parties advocating for it to come to terms on its critical back end: community-based care.\textsuperscript{75} The bipartisan alliance held together, he says, “just long enough to move people with disabilities out of expensive institutional placements,” but it broke down “when the time came to invest in community services.”\textsuperscript{76}

B. The Standards and Practices of Commitment in the States Today

Today, substantive standards for commitment vary by state (which is nothing new),\textsuperscript{77} but the constitutional bottom line is that a person cannot be committed unless judged by at least clear and convincing evidence\textsuperscript{78} to pose a danger to self or others because of mental illness.\textsuperscript{79} Some states impose the additional requirement that the danger be imminent or substantial; fewer than half require proof of an overt act showing dangerousness.\textsuperscript{80} A handful of states, including Texas, have effectively broadened the scope of the dangerousness-to-self criterion by defining it to include the inability to provide for one’s basic needs by reason of grave disability.\textsuperscript{81} This interpretation of the dangerousness-to-self criterion has created, in effect, a new standard commonly referred to as the “grave disability” standard.\textsuperscript{82}

\textsuperscript{74} See, e.g., MICHAEL L. PERLIN, THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL 203 (2000) (noting that contrary to negative rhetoric surrounding deinstitutionalization, “[t]he pages of journals such as American Psychologist or Psychiatric Services are regularly filled with reports of successful deinstitutionalization programs”).

\textsuperscript{75} Bagenstos, \textit{supra} note 49, at 5, 9–12.

\textsuperscript{76} Id. at 5.


\textsuperscript{78} Id. at 433.

\textsuperscript{79} CHRISTOPHER SLOBOGIN, MINDING JUSTICE: LAWS THAT DEPRIVE PEOPLE WITH MENTAL DISABILITY OF LIFE AND LIBERTY 6–7 (2006).

\textsuperscript{80} LEVY & RUBENSTEIN, \textit{supra} note 2, at 29–30, 32.

\textsuperscript{81} For example, the grave disability language in Texas’s commitment statute requires that by reason of mental illness the proposed patient be:

(i) suffering severe and abnormal mental, emotional, or physical distress;

(ii) experiencing substantial mental or physical deterioration of the proposed patient’s ability to function independently, which is exhibited by the proposed patient’s inability, except for reasons of indigence, to provide for the proposed patient’s basic needs, including food, clothing, health, or safety; and

(iii) unable to make a rational and informed decision as to whether or not to submit to treatment.

\textsuperscript{82} See \textit{LEVY & RUBENSTEIN, supra} note 2, at 30 (discussing the contours of behavior that can lead to an individual’s categorization as “gravely disabled” in some states). In addition, people who are admitted involuntarily to psychiatric hospitals are typically entitled to a preliminary hearing to determine whether there is probable cause to believe that the legal standard for commitment is met. See \textit{APPELBAUM, supra} note 23, at 27–28 (discussing a case marking a “[r]eformation of [c]ommitment [l]aw” in which the court “ruled that a preliminary hearing must be held within 48 hours of [involuntary] detention to determine whether probable cause existed to believe that the
Data show that states’ adoption of the dangerousness standard had “little impact on the real world” and that commitment rates in most states did not fall significantly when dangerousness replaced need for treatment as the legal standard. Numerous studies have documented this phenomenon. Professor of psychiatry Paul Appelbaum conducted a meta-analysis of such studies and concluded that decision makers have in practice replaced the dangerousness standard with a “commonsense” approach—essentially, the old need for treatment standard. Indeed, there is a near consensus among commentators that the legal standards for commitment are typically “not respected or followed,” in part because “lawyers do not advocate that existing legal standards be applied to their clients, and judges frequently do not enforce them, but also because mental-health professionals routinely fudge their clinical findings in order to commit people who in their judgment need treatment but who nonetheless decline it. Moreover, courts defer to the judgments of psychiatrists at commitment hearings almost as a matter of course, despite overwhelming evidence that psychiatrists cannot reliably

person was committable”). In Texas, these hearings use a relaxed version of the rules of evidence in which hearsay is admissible such that a person can be detained on the basis of hearsay alone—offered, for example, by a family member, social worker, psychiatrist, or police officer—until the commitment hearing up to two weeks later. See TEX. HEALTH & SAFETY CODE ANN. § 574.005 (West 2010) (designating a two-week time period during which the commitment hearing following the initial application for commitment must be held); id. § 574.025(e) (providing that the judge presiding over such a probable cause hearing “may consider evidence, including letters, affidavits, and other material, that may not be admissible or sufficient in a subsequent commitment hearing”).

83. LEVY & RUBENSTEIN, supra note 2, at 34; see also, e.g., PESZKE, supra note 54, at 115 (finding “no evidence” that the number of people committed in Connecticut decreased after the state changed its commitment laws to require a finding of dangerousness). Note that it was the policy mandating that treatment occur in the least restrictive setting—not the adoption of the dangerousness standard—that was the impetus for deinstitutionalization. See supra notes 62–66 and accompanying text.

84. See APPELBAUM, supra note 23, at 33–48 (assessing studies of the effects of commitment law reforms and finding that there was an “underlying consensus” among major participants in the civil commitment system that mental illness and an evident need for treatment, rather than imminent physical harm, were sufficient for involuntary commitment).

85. LEVY & RUBENSTEIN, supra note 2, at 34.

86. See PERLIN, supra note 74, at 85–86 (noting this phenomenon and quoting a doctor’s reaction to the changed civil commitment standards: “Doctors will continue to certify those whom they really believe should be certified. They will merely learn a new language” (quoting William O. McCormick, Involuntary Commitment in Ontario: Some Barriers to the Provision of Proper Care, 124 CANADIAN MED. ASS’N J. 715, 717 (1981)).

87. BRUCE J. WINICK, CIVIL COMMITMENT: A THERAPEUTIC JURISPRUDENCE MODEL 48 (2005) [hereinafter WINICK, CIVIL COMMITMENT]; Winick, supra note 53, at 41 (“In practice, commitment hearings tend to be brief and non-adversarial episodes in which judges appear to ‘rubber stamp’ the recommendations of clinical expert witnesses.”).
predict dangerousness.\textsuperscript{88} The result, of course, is that the process afforded proposed patients at commitment hearings “is often grossly inadequate.”\textsuperscript{89}

Not only does this circumstance demean the law, it also increases the chance for prejudice to influence commitment decisions because so-called common sense is often infused with stereotypes about—and prejudice toward—people with mental illness.\textsuperscript{90} Arguably, the practice of ignoring the laws on commitment itself evinces prejudice toward people with mental illness by implicitly designating them as unworthy of the law’s protection. Because stereotypes tend to be baked in—often unconsciously—to judgments based on “ordinary common sense,”\textsuperscript{91} it is likely that a great many commitments would not satisfy the dangerousness standard if faithfully applied.\textsuperscript{92} As a prominent psychiatrist argued in the 1970s in protest of the states’ adoption of the dangerousness standard, if dangerousness is understood “in its legal sense and in the sense that it is commonly used, then very few patients will be or can be committed.”\textsuperscript{93} Because the dangerousness standard frequently yields to common sense in commitment decisions, and because common sense is susceptible to bias, many commitment decisions likely constitute discrimination.

III. How and Why Stereotypes About Mental Illness Influence Commitment Decisions

To lay the foundation for a theory of discriminatory commitment based on stereotyping, the concept of a “stereotype” must be fleshed out. It may also be helpful to consider some specific, common stereotypes about people with mental illness that have already been identified. I take up these projects in turn.

Stereotype entered our lexicon as the name for a printmaking process used to make metal printing plates from papier-mâché molds created from the composed type.\textsuperscript{94} In modern usage, however, stereotype is almost always

\begin{footnotes}
\item[88] See, e.g., LEVY & RUBENSTEIN, supra note 2, at 30 (“There is a substantial body of research documenting the inability of psychiatrists to make reliable predictions of future violent behavior.”); JOHN MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR 60 (1981) (noting psychiatrists and psychologists predict incorrectly two out of three times); PERLIN, supra note 74, at 84–87 ( remarking on the unreliability of psychiatric predictions of dangerousness); PESZKE, supra note 54, at 115–16 (conceding that psychiatrists “have poor predictive ability” as to dangerousness and that “[i]n those jurisdictions in which dangerousness is invoked as the only criterion [for commitment], then society might as well employ sociologists, statisticians and attorneys to make predictions, and there is no reason for psychiatrists or physicians to intervene”).
\item[89] LEVY & RUBENSTEIN, supra note 2, at 34.
\item[90] See Michael L. Perlin, On “Sanism,” 46 SMU L. REV. 373, 400–02 (1992) (describing “ordinary common sense” as reinforcing stereotypes about people with mental illness).
\item[91] Id. at 375, 400–02.
\item[92] APPELBAUM, supra note 23, at 33–48 (discussing studies that conclude that people are committed even though they do not meet the dangerousness standard).
\item[93] PESZKE, supra note 54, at 116.
\item[94] THE OXFORD ENGLISH DICTIONARY 651 (2d ed. 1989).
\end{footnotes}
used to mean “[a] preconceived and oversimplified idea of the characteristics which typify a person, situation, etc.” 95 The public intellectual Walter Lippmann minted this new, figurative sense of the word in 1922 to describe the phenomenon by which “[w]e do not first see, and then define, we define first and then see.” 96 Lippmann put it eloquently: “In the great blooming, buzzing confusion of the outer world we pick out what our culture has already defined for us, and we tend to perceive that which we have picked out in the form stereotyped for us by our culture.” 97 As a cognitive heuristic or shortcut, stereotyping saves time but is necessarily reductive. 98 Thus, although stereotypes purport to describe objective reality, they often bear only a warped, tangential relation to it. 99 Soon after Lippmann coined the modern, figurative sense of stereotyping, the concept became a “major theme in American civil rights discourse”—especially in the areas of race and gender discrimination. 100 Thanks to the robustness of this discourse, most of the common stereotypes about race and gender are easily identified as such. But stereotypes about people with mental illness are somewhat less easy to identify, perhaps because they are so reflexively accepted as true—even by people quick to decry analogous prejudices involving sex, race, ethnicity, or sexual orientation 101—that many (if not most) people fail to recognize them as stereotypes.

Among the most harmful stereotypes about people with mental illness is that they are prone to violence. The pervasiveness of this stereotype 102—and the harm it causes both individuals with mental illness and the public at large 103—is well documented. The stereotype is also likely baseless: there is

95. Id.
96. WALTER LIPPMANN, PUBLIC OPINION 81 (Transaction Publishers 1998) (1922); see also THE OXFORD ENGLISH DICTIONARY, supra note 94, at 651 (citing Lippmann as the originator of this sense of the word).
97. LIPPMANN, supra note 96, at 81.
99. See Perlin, supra note 90, at 389 (highlighting how stereotypes serve to perpetuate social and cultural myths).
100. Franklin, supra note 98, at 107. The Oxford English Dictionary notes the term’s appearance in a psychology handbook as a synonym for bias and prejudice. THE OXFORD ENGLISH DICTIONARY, supra note 94, at 651.
103. See ACHIEVING THE PROMISE, supra note 8, at 4. As the President’s New Freedom Commission on Mental Health warned:

Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental disorders . . . . It leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care.

Responding to stigma, people with mental health problems internalize public attitudes
overwhelming evidence that there is at most a very weak link between mental illness and violence.104 In the wake of national tragedies perpetrated by active shooters, this stereotype has become even more pervasive,105 in part because of its frequent deployment as a cheap political countermeasure. In response to the massacre in Newtown, Connecticut, in 2012, the National Rifle Association used the stereotype as political chaff—evidence “that mental illness, and not the guns themselves, was at the root of recent shooting sprees.”106 The group even “called for a national registry of people with mental illness.”107 Legislators in several states introduced bills that would infringe the privacy rights of people with mental illness, drawing sharp criticism from disability-rights advocates and others who decried the proposals as a politically expedient means to avoid engaging the gun lobby.108 The data on the relationship between mental illness and violence speak for themselves, yet the stereotype that people with mental illness are prone to violence persists. It is not difficult to imagine how the stereotype might influence assessments of dangerousness not only by mental-health professionals but also by courts.

and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment.

Id. (citation omitted).


108. Goode & Healy, supra note 104.
Professor Michael Perlin, a leading authority on disability rights, catalogued what he considers the most pervasive stereotypes about people with mental illness in his article *On ‘Sanism,’* which identifies prejudice against people with mental illness as an “ism” no less objectionable than others such as sexism or racism. According to Perlin, society believes that people with mental illness—and I summarize—“simply don’t try hard enough”; “give in too easily to their basest instincts, and do not exercise appropriate self-restraint”; “are erratic, deviant, morally weak, sexually uncontrollable, emotionally unstable, superstitious, lazy, ignorant and demonstrate a primitive morality”; are more dangerous than people who are not mentally ill; are easily and accurately identified as dangerous by experts; need to be committed for refusing to take prescribed medication; and “lack the capacity to show love or affection.” People with mental illness may also be considered “less than human” and incapable or unworthy of relationships with people without mental illness. As “public attitudes,” these stereotypes pervade our social institutions, including our courts, hospitals, and academies. Hence, these institutions can work to reinforce rather than dispel these stereotypes.

Psychiatry, for example, may reinforce stereotypes about people with mental illness by imbuing them with the legitimacy of “science.” Until the 1970s, the American Psychiatric Association’s Diagnostic and Statistical Manual (known colloquially as the DSM), the foundational text of modern psychiatry, described homosexuality as a mental illness. Indeed, stereotypes about mental illness are frequently combined with stereotypes about sex and other immutable characteristics, such as race and ethnicity. In the twentieth century, the erroneous belief that Jews were predisposed to mental illness became so “embedded in scientific (and therefore reliable)
dogma” that even many Jews accepted it as true.117 Similarly, black students have historically been more likely than white students to be assigned to special education programs.118 Given this, it should come as no surprise that blacks are committed at higher rates than whites.119 Stereotypes also associate mental illness with femininity and, as already noted, homosexuality. In the 1950s, social science purported to confirm the validity of traditional gender roles with “scientific” evidence that the “masculine male and feminine female . . . typify mental health.”120 Patriarchal society has long gendered madness female,121 but postnatal women—having just performed (what was viewed as) the ultimate act of womanhood—were regarded as being especially “mentally impaired.”122

Stereotypes also associate mental illness with creativity.123 In the twentieth century, psychiatrists fixed on the literary and artistic productions of people with mental illness as a tool for diagnosis and treatment.124 For a time, psychiatrists scrutinized the “unique artistic productions” of people diagnosed with schizophrenia as projections of the condition’s essential structure.125 In a study that exemplified the circularity of stereotypic logic, researchers “took a group of patients labeled as insane, examined their products . . . and determined that the patients were insane.”126 Another study “drew parallels” between the works of people diagnosed with schizophrenia

117. SANDER L. GILMAN, DIFFERENCE AND PATHOLOGY: STEREOTYPES OF SEXUALITY, RACE, AND MADNESS 232–33 (1985). Adolph Hitler even used this stereotype in his anti-Semitic propaganda; later, he experimented with “euthanasia” on many of the patients committed to German hospitals before sending Jews and others to the death camps en masse. Id. at 233–37.

118. See generally COUNCIL FOR EXCEPTIONAL CHILDREN, ADDRESSING OVER-REPRESENTATION OF AFRICAN AMERICAN STUDENTS IN SPECIAL EDUCATION (2002) (documenting this phenomenon).


120. Franklin, supra note 98, at 112 (quoting Sandra L. Bem & Ellen Lenney, Sex Typing and the Avoidance of Cross-Sex Behavior, J. PERSONALITY & SOC. PSYCHOL. 48, 48 (1976)); see also id. (“[H]ealthy psychological development depended on the extent to which a child identified with a parent of the same sex.”).

121. See, e.g., JANE M. USSHER, THE MADNESS OF WOMEN: MYTH AND EXPERIENCE 8 (2011) (discussing sociocultural theories developed to explain the higher incidence of “madness” in females).


123. See GILMAN, supra note 117, at 241 (asserting that psychiatry has long noted an “association [between] creativity and pathology”).

124. See id. at 225–26 (observing that “[t]wentieth-century psychiatry has been greatly interested in the implications of the artistic and poetic products of the schizophrenic,” which “assumed a greater and greater role in both diagnosis and treatment”).

125. See id. (relating the theory, subscribed to by some twentieth-century psychiatrists, that schizophrenics’ altered relationship to their sense of self could be “extrapolated from the nature of their art”).

126. Id. at 227.
and members of “the avant-garde [art movement], specifically . . . [Wassily] Kandinsky.”

While improvements in the scientific rigor of psychological research since the 1970s have aided the mental-health professions in eschewing quackery, as long as stereotypes about people with mental illness pervade the cultural ether, they will continue to infect judgments made by people in their personal as well as professional capacities—including as doctors, lawyers, and judges. Troublingly, reliance on stereotypes in decision making can “preclude[] empathic behavior,” increasing the likelihood that commitment decisions based on common sense will not only miss the mark but will do so in ways that are insensitive and harmful to people with mental illness.

IV. A Two-Part Theory of Disability Discrimination in the Context of Involuntary Commitment

I describe disability discrimination in the context of involuntary commitment as something of a Gordian knot because, to those like Szasz who would argue for the abolition of commitment, commitment is indistinguishable from discrimination—it is discrimination.130 For abolitionists, the knot cannot be untangled; it must be cut. But if we reject this absolutist view and accept that commitment is not really discrimination—that is, not discrimination in the pejorative sense—then what does it mean to discriminate in the context of involuntary commitment?

This Part sets out a two-pronged theory of discriminatory commitment that intervenes at each of two distinct phases in the commitment process: the decision phase, in which mental-health professionals decide that a person meets the standards for involuntary commitment, and the provision phase, in which the treatment service—the commitment—is actually provided or carried out. As to the first phase (the decision phase), I argue in subpart A that commitment is discriminatory when the commitment decision is based on prejudice toward or stereotypes about people with mental illness, and I suggest several ways that such decisions can be effectively identified. I refer to discrimination that occurs in this phase of the commitment process as “discriminatory-decision.” As to the second phase (the provision phase), I

127. Id.


129. Perlin, supra note 88, at 380–81. “We think of the stereotyped as ‘them’ and not ‘us’ [and we are therefore] less likely to share in their pain and humiliation.” Id. at 380 (quoting Thomas Ross, The Rhetoric of Poverty: Their Immorality, Our Helplessness, 79 GEO. L.J. 1499, 1542 (1991)) (internal quotation marks omitted).

130. SZASZ, supra note 16, at 98; see also WINICK, CIVIL CONFINEMENT, supra note 87, at 102 (“Th[e] discrepancy between [how civil commitment treats] those with mental illness and all others raises a serious equal protection question, and demands that the state justify such discrimination based on compelling necessity.”).
argue in subpart B that commitment is discriminatory when its provision—that is, its execution or administration—fails to reasonably accommodate the committed person’s disability. I refer to this kind of discrimination as “discriminatory-provision.” I introduce each kind of discrimination with a case study that illustrates how it manifests and, I hope, why its victims deserve a remedy.

A. Discriminatory-Decision Commitment: When the Commitment Decision Is Based on Stereotypes or Prejudice

Following is a short case study that illustrates how discriminatory-decision commitment typically manifests. I hope that in addition to performing an illustrative function, it also prods the conscience and evokes an intuitive sense that commitment decisions based on prejudice or stereotypes perpetrate a grave injustice that demands a remedy. Brett Bolmer’s case is significant because it is the first and only case in which a federal court of appeals has recognized a cause of action under the ADA for a commitment decision made on the basis of stereotyping.\(^\text{131}\) It bears emphasis, however, that Bolmer’s case is not unique but is part of a discrete class of cases in which commitment decisions are based on stereotypes about people with mental illness.\(^\text{132}\)

* * *

Brett Bolmer was a resident in a state-run transitional living program that provided community-based housing for people with a history of mental illness.\(^\text{133}\) The program appointed a case manager to monitor and facilitate Bolmer’s participation in the program.\(^\text{134}\) Shortly after the case manager’s appointment, she and Bolmer began texting and calling each other

\(^{\text{131}}\) Bolmer v. Oliveira, 594 F.3d 134, 149 (2d Cir. 2010).

\(^{\text{132}}\) For another archetypical case of discriminatory-decision commitment with an intriguing factual premise—a nudist with bipolar disorder riding her bicycle in the rain, committed because a psychiatrist believed the political and philosophical beliefs informing her choice to lead a “clothing-optional” lifestyle were “clearly delusional” and that riding nude in the rain might lead to assault, see State v. Webb, 63 P.3d 1258, 1259, 1261 (Or. Ct. App. 2003). The discrimination here is that had the nudist not had bipolar disorder, she would not have been committed. Because of her disability status, she was presumed incapable of holding the set of political and lifestyle preferences called nudism—she was presumed, in other words, incapable of being a nudist. It is not difficult to imagine a person with bipolar disorder being committed on account of their participation in a host of other similarly “dangerous” activities such as extreme sports, political protests like Occupy Wall Street, or promiscuous sex. This kind of discrimination singles out people with mental illness for different treatment on account of disability, confining them to cramped, normative conceptions of the good life.

\(^{\text{133}}\) Bolmer, 594 F.3d at 137.

\(^{\text{134}}\) Id.
frequently. This developed into a sexual relationship, and for several months they met once or twice a week at the caseworker’s apartment.

The relationship ended, and Bolmer expressed his anguish to the director of the housing program; the case manager, however, denied the relationship. She reported “that Bolmer had left flowers on her car and had called her twice.” Believing the relationship was a delusion, the program staff asked Bolmer to report for a psychological evaluation to determine whether he was manifesting “erotomania,” a condition characterized by an erroneous belief in a sexual relationship with another person.

Bolmer was upset upon reporting for the evaluation; he spoke loudly and expressed his sense of indignation. A psychiatrist conducted an examination that lasted fewer than fifteen minutes. According to Bolmer, the hospital staff “kept looking at [him] as if [he] was crazy to be thinking that a case worker could possibly have an affair with a crazy person.” When Bolmer realized the psychiatrist was considering whether to commit him, he attempted to express his feelings about the breakup. The psychiatrist rolled his eyes at Bolmer and warned him to calm down. Bolmer tried to convey that he was not angry by stating that “if [he] was really angry that [he] would pick up the chair in the room and throw it.” At this point, the psychiatrist opened the door, and police and medical workers rushed into the room.

The psychiatrist had Bolmer committed. After Bolmer’s personal effects were confiscated, he was strapped to a bed and injected with an antipsychotic medication. Only later did the hospital staff discover text messages and calls on Bolmer’s cell phone that substantiated his account of the relationship and confirmed it was not a delusion.
Discrimination involves, most basically, the making of distinctions.\textsuperscript{150} In the modern American lexicon, however, the word discrimination is pregnant with political meaning and tends to imply the making of distinctions that are illegitimate or unjustified.\textsuperscript{151} In the wake of the civil rights movement, the principle that discrimination is illegitimate when based on race, for example, seems self-evident to most people. Thus, it is probably safe to assume that, in general, people consider decisions more legitimate when not based on discrimination as to a characteristic such as race, sex, or—if our antidiscrimination law is any indication—disability.

But decisions about commitment, I want to suggest, are different. When discrimination is considered in the context of commitment, a curious problem emerges: the legitimacy of commitment depends on discrimination. That is, the legitimacy of commitment depends on the ability of decision makers to discriminate perfectly among members of a protected class—people with mental illness—and to commit only those whose disability takes a particular form (i.e., dangerousness to self or others). In this respect, the law of civil commitment is like the criminal law in that its legitimacy depends on discrimination. Whereas the criminal law must discriminate on the basis of criminality, the law of civil commitment must do so on the basis of disability. The difference, of course, is that disability, unlike criminality, is a prohibited basis for discrimination under the law.\textsuperscript{152} This may seem to make the very notion of nondiscriminatory commitment incoherent.\textsuperscript{153}

If commitment necessarily discriminates on the basis of disability, the next question is: when, if ever, is such discrimination legitimate? In other words, when is discrimination not really discrimination—that is, when is it not discrimination in the pejorative sense? An obvious answer is: when the discrimination is not based on prejudice or stereotypes about people with mental illness. Under this view, the commitment decision is discriminatory—that is, illegitimate—only when it is based on prejudice or stereotypes. This principle is intuitive because it comports with normative

\footnotesize{\textsuperscript{150} See BRYAN A. GARNER, GARNER’S MODERN AMERICAN USAGE 264 (3d ed. 2009) (defining “discriminate” as “to make a clear distinction”).
\textsuperscript{151} See ROBERT K. FULLINWIDER, THE REVERSE DISCRIMINATION CONTROVERSY 11–12 (1980) (“The dictionary sense of ‘discrimination’ is neutral while the current political use of the term is frequently non-neutral, pejorative.”).
\textsuperscript{152} See, e.g., Americans with Disabilities Act, 42 U.S.C. § 12112(a) (2012) (“No covered entity shall discriminate against a qualified individual on the basis of disability in regard to . . . employment.”).
\textsuperscript{153} See, e.g., Estate of Awkward v. Willingboro Police Dep’t, No. 07-5083(NLH), 2010 WL 3906785, at *13 (D.N.J. Sept. 30, 2010) (“[A]n accusation that an individual was involuntarily committed on the basis of a mental disability] cannot serve as a basis for an ADA . . . violation for disability discrimination because such a finding would convert every involuntary commitment . . . into a civil rights violation.”).}
understandings of discrimination as rooted in prejudice.154 Moreover, as a practical matter, it focuses the inquiry on a single factual question that courts are equipped to answer: whether prejudice or stereotypes about people with mental illness have infected the commitment process.

But answering this question becomes more complicated when a commitment decision is based—as it typically is—on the opinion of a medical expert such as a psychiatrist or psychologist.155 Medical science, especially in the context of mental illness, is to some extent socially constructed156 and therefore influenced by the same prejudices and stereotypes that influence public views generally. But courts may fail to recognize this.157 Moreover, courts routinely defer to the judgments of psychiatrists158 despite uncontroverted evidence that psychiatrists cannot accurately predict dangerousness159—which is, of course, the only legal basis for commitment.160 Thus, courts should more critically examine the findings of the state’s medical experts as to dangerousness and not assume that medical opinions escape the biases inherent in common sense.

1. Legislative Solutions.—This Note’s primary focus is the development of a two-pronged theory of discrimination that is actionable under the ADA. This is a back-end approach in that it seeks to remedy discrimination after it occurs. (Of course, the threat of litigation also serves a deterrent function.) But discrimination in commitment decisions also could be reduced—and reduced more directly—through front-end legislative reforms.

One such reform is procedural. States could furnish independent psychiatrists to serve as expert witnesses for proposed patients who are indigent and cannot afford an expert.161 When there is room (as often there is) for psychiatrists to reach different conclusions about whether a proposed patient meets the legal standard for commitment, courts would benefit from a broader range of psychiatric opinion. In particular, courts would benefit from the opinion of psychiatrists who do not work for the state and who did

154. See Fullinwider, supra note 151, at 11–12 (“The dictionary sense of ‘discrimination’ is neutral while the current political use of the term is frequently non-neutral, pejorative.”).
155. Miller, supra note 65, at 12.
156. Cf. Nancy Ehrenreich, The Colonization of the Womb, 43 DUKE L.J. 492, 541–43 (1993) (“The association of medicine with reason, facts and objectivity has been challenged through efforts to show that medicine is in fact a product of culture, rather than separate and apart from it—that it is socially constructed.”).
157. Id. at 565.
158. Miller, supra note 65, at 12; see also Ehrenreich, supra note 156, at 566 (“Legal authorities in general pay great deference to medical expertise.”).
159. See supra note 88 and accompanying text.
160. That is, the minimum legal basis. As already noted, some states impose additional requirements that result in a heightened standard. See supra notes 80–82 and accompanying text.
161. See supra note 15.
not help initiate the commitment process in the first place.\textsuperscript{162} Some jurisdictions have already recognized this.\textsuperscript{163} Connecticut, for example, requires that two impartial psychiatrists selected by the court evaluate the proposed patient and report their findings to the court before a commitment order can issue.\textsuperscript{164}

For additional precedent, we need look no further than the criminal law, where both federal and state statutes provide indigent defendants with access to expert witnesses when necessary for the mounting of an adequate defense.\textsuperscript{165} Writing from the New York Court of Appeals bench in 1929, then-Judge Benjamin Cardozo called it “a matter of common knowledge” that “upon the trial of certain issues, such as insanity . . ., experts are often necessary both for prosecution and for defense,” and that in such cases, “a defendant may be at an unfair disadvantage, if he is unable because of poverty to parry by his own witnesses the thrusts of those against him.”\textsuperscript{166} Cardozo directed his remarks at the criminal context, but they apply with equal force in the context of civil commitment, where personal liberty and other basic rights are likewise at stake.

At most commitment hearings, the psychiatrist is the state’s most important witness. Some commentators have gone so far as to argue that the current legal regime “in effect delegates to clinicians who perform evaluations for the courts the power to make decisions about when an individual’s liberty should be taken away.”\textsuperscript{167} Even when a proposed patient’s family members or friends testify persuasively on the question of whether the proposed patient is dangerous, the court typically relies on the state’s psychiatrist to supply the all-important medical frame for the narrative that evolves.\textsuperscript{168} Because a proposed patient must be found dangerous because

\begin{itemize}
\item\textsuperscript{162} The state typically initiates a commitment proceeding by filing an application for court-ordered mental health services supported by a medical certificate completed by a state psychiatrist. Michael Churgin, Raybourne Thompson Centennial Professor, Univ. of Tex. at Austin Sch. of Law, Lecture at the Mental Health Clinic (Jan. 2014).
\item\textsuperscript{163} Winick, \textit{supra} note 53, at 40.
\item\textsuperscript{164} CONN. GEN. STAT. ANN. § 17a-498(c) (West 2006 & Supp. 2014).
\item\textsuperscript{165} See, e.g., 18 U.S.C. § 3006A(e)(1) (2012) (requiring that indigent criminal defendants be provided “expert . . . services necessary for adequate representation”); United States v. Patterson, 724 F.2d 1128, 1130 (5th Cir. 1984) (interpreting that statute as requiring that “where the government’s case rests heavily on a theory most competently addressed by expert testimony, an indigent defendant must be afforded the opportunity to prepare and present his defense to such a theory with the assistance of his own expert”); Paul C. Giannelli, Ake v. Oklahoma: The Right to Expert Assistance in a Post-Daubert, Post-DNA World, 89 CORNELL L. REV. 1305, 1332 (2004) (stating that “most jurisdictions have provisions for court-appointed experts” for indigent criminal defendants).
\item\textsuperscript{166} Reilly v. Berry, 166 N.E. 165, 167 (N.Y. 1929).
\item\textsuperscript{167} WINICK, \textit{CIVIL COMMITMENT}, \textit{supra} note 87, at 48. Winick locates the problem partly in the “breadth and imprecision of statutory definitions of mental illness,” which he says “both allow and mask arbitrariness and discrimination in the application of the law.” \textit{Id}.
\item\textsuperscript{168} See Addington v. Texas, 441 U.S. 418, 429 (1979) (“Whether the individual is mentally ill and dangerous to either himself or others and is in need of confined therapy turns on the \textit{meaning} of the facts which must be interpreted by expert psychiatrists and psychologists.”); Douglas
of mental illness to be committed, psychiatric testimony is essential to commitment decisions.¹⁶⁹

Like the opinions of any expert witness, a psychiatrist’s judgments are subject to influence by various kinds of bias.¹⁷⁰ For example, a psychiatrist employed by a state hospital may have chosen to practice psychiatry in that setting in part because she sincerely believes in the model of care it provides.¹⁷¹ Coercion—involuntary commitment and involuntary treatment (including, in some jurisdictions, electroconvulsive therapy)¹⁷²—is at the heart of this model. Thus, because of self-selection effects, psychiatrists


¹⁶⁹. See Addington, 441 U.S. at 429 (describing the importance of expert testimony in determining whether or not an individual is dangerous due to mental illness); Mossman et al., supra note 168, at 366–67 (same).

¹⁷⁰. See David E. Bernstein, Expert Witnesses, Adversarial Bias, and the (Partial) Failure of the Daubert Revolution, 93 IOWA L. REV. 451, 453 (2008) (arguing that expert witnesses are “uniquely vulnerable to ‘adversarial bias’”); id. at 480–81 (classifying “psychiatric diagnoses based primarily on training and experience” as “connoisseur testimony,” meaning that “it has no objective basis and, given selection bias, its underlying reliability in any given case is therefore completely opaque”).

¹⁷¹. The professional judgments of a psychiatrist at a private hospital may also be subject to influence by economic pressures: private psychiatric hospitals have a strong financial incentive to keep beds filled, and their willingness to tweak diagnoses and to use the threat of commitment to keep patients hospitalized “voluntarily” in order to collect insurance payments is well documented. See, e.g., ARNOLD BIRENBAUM, MANAGED CARE: MADE IN AMERICA 124 (1997) (noting that with the rise of managed care, “some . . . private psychiatric hospitals offered bounties for patients, violating the rights of ordinary citizens to due process in the course of an involuntary commitment”); Peter Kerr, 8 Big Insurers Sue National Medical Enterprises, N.Y. TIMES, July 31, 1992, at D1, available at http://www.nytimes.com/1992/07/31/business/8-big-insurers-sue-national-medical-enterprises.html, archived at http://perma.cc/9U7F-6ZE6 [hereinafter Kerr, 8 Big Insurers] (reporting on a lawsuit filed by eight leading insurance companies alleging that “National Medical Enterprises, one of the nation’s largest operators of psychiatric hospitals . . . systematically manipulated the diagnoses of patients to keep them in hospitals until their health insurance coverage was exhausted”). In one harrowing example, Peter Kerr explained:

In Texas, Susan Alderson, a former patient at a Psychiatric Institutes center in Farmers’ Branch, Tex., said the staff had told her they were trying to change her diagnosis . . . to increase her coverage to $1 million from $50,000 and prolong her stay. Ms. Alderson told a legislative committee that when she protested, the hospital punished her by taking away privileges and telling her she would be in a mental hospital the rest of her life.


¹⁷². See, e.g., CONN. GEN. STAT. ANN. § 17a-543(c) (West 2006 & Supp. 2014) (specifying circumstances under which an involuntary patient may receive electroconvulsive therapy over her objections); 405 ILL. COMP. STAT. ANN. § 5/2-107(a), (h) (West 2011 & Supp. 2014) (same); MO. ANN. STAT. § 630.130.3 (West 2014 & Supp. 2015) (same).
employed at state hospitals may tend to make professional judgments—including judgments of dangerousness—that lead to the proposed patient’s being treated in the state hospital because that is the setting they consider most efficacious.\textsuperscript{173}

But there is also room in psychiatric practice to draw other conclusions about what treatment setting is most efficacious, including the conclusion that coerced treatment in an institutional setting is less effective than voluntary treatment in the community.\textsuperscript{174} This is unqualifiedly the view of Harvard Medical School psychiatrist Christopher Gordon.\textsuperscript{175} A psychiatrist holding this view might well tend to make professional judgments—including judgments of dangerousness—that would lead to fewer involuntary commitments.

Without access to an independent psychiatric examination, the proposed patient has only inadequate means to challenge the testimony of the state’s psychiatrist. The proposed patient’s attorney may, of course, attempt to impeach the psychiatrist’s testimony by cross-examination, but the attorney almost certainly lacks the medical expertise—and thus the credibility—to seriously call into question the medical basis of the psychiatrist’s opinion. Besides, an attorney’s statements in examining a witness are (of course) nontestimonial, so cross-examination affords only a chance to weaken the psychiatrist’s testimony—not affirmatively contradict it. The proposed patient’s attorney also could use the state’s psychiatrist to introduce a learned treatise that contradicts the psychiatrist’s testimony,\textsuperscript{176} but as a practical matter the in-person testimony of a psychiatrist, unless truly far afield, is likely to carry significantly more weight than any treatise offered to contradict it.

Providing for independent psychiatric evaluations would decrease courts’ reliance on the state’s psychiatrists and help educate courts on medical matters beyond their expertise—matters that might well be controversial within the field of psychiatry itself.\textsuperscript{177} Over time, courts with

\textsuperscript{173} See, e.g., Mossman et al., supra note 168, at 452 (“Psychiatrists typically think of civil commitment as a vehicle for making sure their patients get the treatment they need, having made a clinical assessment that such treatment is critical.”); cf. Paul S. Appelbaum & Thomas G. Guthel, Clinical Handbook of Psychiatry and the Law 37 (4th ed. 2007) (“Often, the only reasonable option for dealing with a psychiatric emergency is to seek the patient’s hospitalization.”).


\textsuperscript{175} See id. (criticizing “mandated treatment” for many patients with psychotic symptoms).

\textsuperscript{176} See Bernstein, supra note 170, at 472 n.104 (citing admission of psychiatric treatises and textbooks under Daubert).

regular access to a broader range of psychiatric perspectives could accumulate valuable, well-balanced institutional knowledge. This would go far in helping courts spot psychiatric testimony informed by stereotypes or prejudice about people with mental illness. And, critically, it would help courts identify stereotypes and prejudices that inform their own judgments as well. When the only psychiatrist in the room testifies in case after case that the proposed patient is dangerous, it is no wonder that courts may come to view people with mental illness as being more dangerous than empirical evidence shows.

Another reform that would improve courts’ ability to discern the influence of stereotypes and prejudice in assessments of dangerousness is the requirement of an overt act. Courts are familiar with the concept of overt acts from the law of conspiracy. An overt act requirement makes the dangerousness standard more concrete and renders judicial decisions more transparent because judges cannot base their findings on mere speculation—whose relation to prejudice may be difficult to ascertain—but instead must point to an overt act whose occurrence may be easier as an evidentiary matter to establish or disprove. This makes determinations of dangerousness less subjective and more amenable to appellate review. Moreover, “[t]he strong consensus of the risk literature is that the number and type of prior violent acts committed by an individual are the factors most germane to a prediction of future behavior.”

A shortcoming of the overt act requirement, however, is that it can become a mere formality when courts take a permissive view of what constitutes an overt act. For example, a Texas appellate judge has stated that he “would find the continuous refusal to take medication an overt [act].” A Texas appellate court has held that a woman’s “disruptive and disorganized behavior at home” and “bizarre behavior” in a hospital constituted overt acts. And the Montana Supreme Court has held that a man’s statement that his psychiatrist “was a pimp” and that “there were political reasons for [the psychiatrist’s] going to court to have [him] committed” were overt acts.

178. See generally United States v. Connor, 537 F.3d 480, 484 (5th Cir. 2008) (outlining the overt act requirement in a case involving conspiracy to use unauthorized access devices); Note, Criminal Conspiracy: Bearing of Overt Acts upon the Nature of the Crime, 37 HARV. L. REV. 1121, 1121–24 (1924) (discussing various types of cases involving the overt act requirement of conspiracy).

179. See In re Det. of Anderson, 211 P.3d 994, 1000 (Wash. 2009) (“The purpose behind the recent overt act requirement is to add objectivity to an otherwise subjective determination of mental illness and dangerousness.”).

180. Id.


At the first commitment hearing I observed in a probate court in Travis County, Texas, the overt act on which the commitment order rested was the proposed patient sticking out her foot as though to trip another patient but not in fact tripping him.

Mindful of this shortcoming of the overt act requirement and of the inability of mental-health professionals to predict dangerousness generally, some commentators have called for the replacement of these predictive tools with statistical algorithms that draw on large empirical data sets to predict a person’s potential for violence given a set of risk factors. Such methods show promise for improving the accuracy, reliability, and transparency of dangerousness assessments, and courts in at least two jurisdictions with overt act requirements have commented positively on their potential to improve the fairness of the dangerousness standard. However, the problem of deciding how dangerous is too dangerous—like the problem of defining how overt is overt enough—will remain.

2. Judicial Solutions.—As for back-end approaches, there is a strong argument to be made that commitment decisions based on stereotypes or prejudice about people with mental illness are actionable under Title II of the ADA, properly construed. Indeed, as discussed in detail below, the Second Circuit and several district courts have taken this position. Wider recognition of an ADA cause of action for commitment decisions based on stereotypes or prejudice would not only help victims obtain redress but also would help deter discriminatory commitment in the first place. Powerful financial incentives operate on physicians at private treatment facilities to keep beds occupied, and commitment—or at least the threat of commitment—is a convenient means of securing a steady flow of insurance payments. Short of inviting physicians to commit outright fraud by systematically manipulating the diagnoses of patients to keep them in hospitals until their health insurance coverage is exhausted—a scandal that rocked the psychiatric world in the 1990s—such incentives may nonetheless compromise the clinical objectivity of physicians assessing dangerousness. Recognizing a remedy under the ADA could help keep thumbs off the scales.

Title II of the ADA provides that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation

185. See, e.g., Mossman et al., supra note 168, at 391 (asserting that “[e]mpirically based, statistical prediction algorithms probably provide more accurate assessments of dangerousness than does the unaided clinical judgment of mental health professionals”).
186. Id. at 451–53.
187. See Kerr, Mental Hospital, supra note 171 (describing the risks staff may face in some psychiatric institutions if they fail to keep the number of patients in each hospital ward at a certain number).
188. See, e.g., id. (providing an example of a hospital staff changing a patient’s diagnosis to extend her stay so they could increase her insurance coverage).
189. Kerr, 8 Big Insurers, supra note 171.
in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” Currently, the Second Circuit is alone among the circuit courts in recognizing a Title II cause of action for claims based on stereotypes. In April 2013, the Third Circuit acknowledged the Second Circuit’s recognition of “claims of disability discrimination under the ADA . . . based on stereotypic assumptions” but declined to decide the question itself. The issue remains unaddressed by the other circuits.

Some lower courts also have recognized a Title II cause of action based on stereotyping, and others have implied that one might exist. The Supreme Court, too, has used language that might signal its openness to such claims. In Olmstead v. L.C. ex rel. Zimring, the Court stated that the “unjustified institutional isolation of persons with disabilities is a form of discrimination.” In analyzing the plaintiffs’ claims under the ADA, the Court held that “undue institutionalization qualifies as discrimination ‘by reason of . . . disability.’” In his concurrence, Justice John Paul Stevens made clear that “[‘unjustified institutional isolation’] constitutes discrimination under the [ADA].”

Taken at face value, the Court’s holding that “undue institutionalization qualifies as discrimination ‘by reason . . . of disability’” would seem to imply that a Title II cause of action lies whenever a person is wrongly committed because a wrongful commitment is by its very nature “undue.” Olmstead’s broad language, interpreted in this way, might obviate the need for a theory of discriminatory commitment based on stereotyping or prejudice because commitment on such grounds presumably would come under the umbrella of undue institutionalization. But lower courts have read Olmstead more narrowly—and the Court probably intended as much. The plaintiffs

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193. See, e.g., Musko v. McClainless, No. 94-3938, 1995 WL 262520, at *6 (E.D. Pa. May 1, 1995) (determining that the plaintiff’s argument that the township treated him differently from others who violate zoning ordinances on account of his disability was sufficient to state a claim under Title II).
194. See, e.g., City of Newark v. J.S., 652 A.2d 265, 276 (N.J. Super. Ct. Law Div. 1993) (describing the ADA as “designed to avoid the risk of stereotyping, bigotry and prejudice by demanding an individualized determination before any adverse action is taken against a person with any disability”).
196. Id. at 600.
197. Id. at 597, 600. 198. Id. at 607 (Stevens, J., concurring).
199. Id. at 597.
200. See, e.g., Winters v. Ark. Dep’t of Health & Human Servs., 491 F.3d 933, 936 (8th Cir. 2007) (distinguishing Olmstead by noting that the holding of that case was limited to “discrimination arising from isolating persons with mental illness in an institution when the state’s own treatment professionals have determined that a community setting would be appropriate”).
in *Olmstead* complained of ongoing, long-term institutionalization that the Court described as undue because the State’s own physicians agreed the plaintiffs were qualified for placement in a community-based treatment setting.\(^{201}\) Thus, courts have interpreted *Olmstead* to mean that undue institutionalization constitutes disability discrimination only as to ongoing, long-term institutionalization not as to initial determinations of whether a person should be committed.\(^{202}\) Although the essential holding of *Olmstead* remains cabined in this way, the general principle it stands for—that undue institutionalization constitutes disability discrimination—may suggest the Court’s receptiveness to a theory of discriminatory commitment under Title II.

A Title II claim brought to contest commitment based on stereotypes or prejudice may be redundant of constitutional and tort claims since a commitment decision made on these grounds fails to satisfy constitutional standards and may constitute the tort of false imprisonment.\(^{203}\) However, a claim brought under Title II adds value in several ways. First, as a purely semantic matter, it calls commitment based on stereotypes and prejudice what it is—discrimination—and thus confers on it a judgment of moral opprobrium.\(^{204}\) More practically, a claim under Title II may provide an important strategic advantage in that constitutional and tort claims are often barred by sovereign immunity and tort claims statutes.\(^{205}\) Title II claims, on the other hand, are not barred by sovereign immunity because Congress “abrogate[d] states’ immunity from Title II claims.”\(^{206}\) And, of course, Title II claims are not torts and therefore are not subject to tort claims statutes. Thus, a Title II claim may provide a discriminatory-decision plaintiff a remedy where otherwise she would have none.\(^{207}\)

\(\text{201. } *\text{Olmstead*}, 527 U.S. at 593–94. \) The question considered by the Court in *Olmstead* was “whether [the ADA’s] proscription of discrimination may require placement of persons with mental disabilities in community settings rather than in institutions.” *Id.* at 587.

\(\text{202. } E.g., ^{*Winters*}, 491 F.3d at 936–37.\)

\(\text{203. } See \text{ generally *Restatement (Second) of Torts* § 35 (1965)} \) (setting out the elements of a false imprisonment claim).

\(\text{204. } See \text{ *Fullinwider*, supra note 151, at 11–12 (“For some, it may be enough that a practice is called discriminatory for them to judge it wrong.”).}\)

\(\text{205. } See, \text{ e.g., *Doe v. Arizona*, } 240 \text{ F. App’x 241, 243 (9th Cir. 2007) (affirming the lower court’s ruling that the action was barred because the State “enjoyed sovereign immunity under the Eleventh Amendment”); *Estate of Awkward v. Willingboro Police Dep’t*, No. 07-5083(NLH), 2010 WL 3906785, at *12–13 (D.N.J. Sept. 30, 2010) (holding that police officers were entitled to qualified immunity on § 1983 claims arising from the death of a man with schizophrenia from “positional asphyxia” and that the tort claims arising from the same events failed because the “defendants were] immune from suit under the New Jersey Tort Claims Act”).}\)

\(\text{206. } ^{*\text{Bolmer v. Oliveira*}, 594 \text{ F.3d 134, 146 (2d Cir. 2010)}.}\)

\(\text{207. In addition, a court’s recognition of an ADA claim may also neutralize the defense of qualified immunity to constitutional claims because “[t]he doctrine of qualified immunity protects government officials ‘from liability for civil damages insofar as their conduct does not violate clearly established statutory . . . rights of which a reasonable person would have known.’” *Estate of Awkward*, 2010 WL 3906735, at *5 (quoting Harlow v. Fitzgerald, 457 U.S. 800, 818.}\)
B. Discriminatory-Provision Commitment: When a Provider of a Service Related to the Commitment Fails to Make Reasonable Accommodations for the Patient’s Disability

In this subpart, I argue that commitment is discriminatory when its provision fails to reasonably accommodate a committed person’s disability, including at the time the person is being taken into custody following the issuance of a commitment order. I refer to this kind of discrimination as “discriminatory-provision.” The premise of my argument is not controversial: it is well accepted that medical service providers who are subject to the ADA must comply with its mandates to reasonably accommodate the disabilities of patients, provided those accommodations do not impose an undue burden. This is the core of Title II. What is controversial, however, is the question of when during the commitment process the ADA’s protections kick in. This Note argues that the ADA’s protections should kick in at the time a person is being taken into custody—for example, during the execution of a commitment order—rather than only after custody is achieved. I begin with a case study to illustrate the problem.

* * *

Tyrone Awkward had a well-established diagnosis of paranoid schizophrenia. After a family party where Awkward behaved erratically, his family contacted the state mental-health department to request that he receive treatment. A police officer accompanied a certified mental-health screener to Awkward’s home to conduct a psychological evaluation and, if necessary, escort Awkward to a hospital.

When the officer and mental-health screener arrived at the home, Awkward’s family told them that Awkward played football and was a big man but that he was a good person and would cooperate. The officer and mental-health screener met with Awkward in the living room and explained “that they were there to help him.” After conducting a short examination,

(1982)). Thus, a valid Title II claim may breathe life into a plaintiff’s constitutional claim arising from the same events.

208. See infra notes 258–61 and accompanying text. This question also arises in the context of criminal arrests, which I distinguish from civil-commitment arrests on several grounds. See infra notes 269–72 and accompanying text.


210. Id.

211. Id.

212. Id.

213. Id.

214. Id.
the screener determined that Awkward needed treatment. At first Awkward refused to go to the hospital, but after some coaxing by the officer, screener, and his mother, “he acquiesced and stood up to put on his shoes.” Even though Awkward agreed to receive treatment voluntarily, the screener completed an involuntary commitment form authorizing the officers to transport Awkward to the hospital.

As an officer escorted Awkward from the house, Awkward stopped abruptly at the door and asked for his hat. The family knew “that [he] always wore a hat outside the home.” Awkward’s sister handed him a baseball cap, “but it was not the hat he wanted.” So Awkward’s mother went upstairs to retrieve the right hat. Rather than wait for Awkward’s mother to return with his hat, the officer continued to lead Awkward out the front door.

When they were just outside the house, Awkward “stopped again upon seeing . . . a third officer” who had arrived as backup and was standing in the front yard. The officer escorting Awkward placed his hand on Awkward’s lower back and assured him that everything would be fine if Awkward would go to the hospital. Awkward then asked why he was being arrested and stated that he did not want to go to the hospital and did not understand why he was being forced to go. He asked again for his hat. Then he turned around and tried to “push past [the officer] . . . to get back inside the house.” At this point, the officer tried to handcuff Awkward, placing one handcuff on Awkward’s wrist while reiterating that Awkward was not being arrested. Then another officer, who had just come outside with Awkward’s hat, moved to help apply the handcuffs. Together with a third officer, they forced Awkward to the ground.

Within minutes, more officers arrived and joined the effort to restrain Awkward, who according to some witnesses was pinned face down on the ground, crying out that he could not breathe. Witnesses said that as many

215. Id.
216. Id. At this point, another officer also had arrived. Id. at *2.
217. Id. at *2.
218. Id.
219. Id.
220. Id.
221. Id.
222. Id.
223. Id.
224. Id.
225. Id.
226. Id.
227. Id.
228. Id.
229. Id.
230. Id.
231. Id.
as ten officers piled on top of Awkward to restrain him.\(^\text{232}\) When Awkward stopped resisting, the officers realized he was unconscious.\(^\text{233}\) Emergency medical workers failed to revive him, and upon reaching the hospital he was pronounced dead.\(^\text{234}\)

\* \* \*

The scene that played out during the execution of Awkward’s commitment order is tragic. It is also unnecessary. A number of cases document similar tragedies—some even more dramatic—that result from failures to reasonably modify commitment procedures to account for the individual needs of a person with mental illness.\(^\text{235}\) It is easy, of course, to second-guess police officers’ decisions with the benefit of hindsight, but Awkward’s case invites the question of what would have happened if the officers had used a different approach—or even just waited for Awkward’s mother to retrieve the right hat.\(^\text{236}\)

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\(^{232}\) Id.

\(^{233}\) Id. at *3.

\(^{234}\) Id.

\(^{235}\) See, e.g., Velasquez v. Audirsch, 574 F. App’x 476, 477–78, 480 (5th Cir. 2014) (denying a § 1983 claim based on police officers’ warrantless search of the house of a man with paranoid schizophrenia who had threatened his neighbor with a knife); Thao v. City of St. Paul, 481 F.3d 565, 566–67 (8th Cir. 2007) (rejecting Title II claim brought against police officers in the shooting death of a man with paranoid schizophrenia who had barricaded himself inside the family home); Heckensweiler v. McLaughlin, 517 F. Supp. 2d 707, 711–13, 722 (E.D. Pa. 2007) (granting in part and denying in part federal and state law claims arising from the suicide of a man with mental illness following a standoff with police attempting to serve him with a commitment order); Hogan v. City of Easton, No. 04-759, 2004 WL 1836992, *1–5 (E.D. Pa. Aug. 17, 2004) (granting in part and denying in part federal constitutional and statutory claims in the shooting of a man with mental illness who was not a “viable threat” following a standoff with police in his home). For more than fifteen additional examples of people with mental illness being seriously injured or killed as a result of law enforcement’s failure to make reasonable accommodations, see AMNESTY INT’L, USA: RACE, RIGHTS AND POLICE BRUTALITY 14–20 (1999) [hereinafter POLICE BRUTALITY REPORT], available at https://www.amnesty.org/en/documents/AMR51/147/1999/en/, archived at https://perma.cc/E7J6-6TP6.

236. Awkward’s case is typical of those in which police fail to accommodate a person’s disability during an “arrest,” but it also is suggestive of discrimination that occurs at the intersection of disability and race. When reading about Awkward’s case, you might have intuited that Awkward was black. Police brutality in the United States has long been associated with racial discrimination; images of white police officers brutalizing racial minorities—in particular, young black men—have reached iconic status and are seared into our national memory. See, e.g., J. David Goodman & Al Baker, Wave of Protests After Grand Jury Doesn’t Indict Officer in Eric Garner Chokehold Case, N.Y. TIMES, Dec. 3, 2014, http://www.nytimes.com/2014/12/04/nyregion/grand-jury-said-to-bring-no-charges-in-staten-island-chokehold-death-of-eric-garner.html, archived at http://perma.cc/U99B-NC6Z (describing the civil rights and antiracism demonstrations that occurred after a grand jury failed to indict a police officer for his role in Eric Garner’s death by chokehold following a routine police stop in July 2014); Kate Mather, Rev. Al Sharpton Calls Rodney King ‘a Symbol of Civil Rights,’ L.A. NOW, L.A. TIMES (June 17, 2012, 11:12 AM), http://latimesblogs.latimes.com/lanow/2012/06/rev-al-sharpton-calls-rodney-king-was-a-symbol-of-civil-rights.html, archived at http://perma.cc/ZA9L-3VJ2 (quoting civil rights leader Al Sharpton as describing Rodney King, whose videotaped beating by police sparked race riots in Los Angeles in 1992, as a “symbol of civil
The second part of the two-part theory of discriminatory commitment developed here governs situations in which a provider of the commitment—that is, an authority involved in its administration—fails to reasonably modify the terms or conditions of the commitment to accommodate needs of the committed person arising from her disability. This kind of discriminatory commitment, which I refer to as discriminatory-provision, differs from discriminatory-decision in several important ways.

First, whereas discriminatory-decision inquires into the justification for the commitment, discriminatory-provision assumes the commitment is justified and instead inquires only into its administration. Thus, discriminatory-provision does not challenge the basis for the commitment but simply asks whether the provider of the commitment—for example, a treatment facility or law enforcement officer—complied with the ADA by reasonably modifying the commitment’s terms or conditions to accommodate needs of the committed person arising from her disability.

This conceptual distinction is reflected in a temporal one. Discriminatory-decision concerns discrimination that occurs at the moment the commitment decision is made. Thus, it focuses on a single point in time that may precede the committed person’s actual confinement. By contrast, discriminatory-provision concerns discrimination that occurs during the commitment’s execution or administration.237 Thus, it focuses on the commitment as it unfolds, although as we saw in Awkward’s case, discriminatory-provision may be especially likely to assume relevance at discrete, predictable points in the commitment process, such as at the time the commitment order is executed.

Title II of the ADA provides that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”238 A “qualified
individual with a disability” is “an individual with a disability who, with or without reasonable modifications to rules, policies, or practices . . . meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.” 239 The right to such modifications is not absolute but contingent: the modifications must not constitute an “undue burden”—that is, they must not entail “a fundamental alteration in the nature of a service, program, or activity or . . . [impose] undue financial and administrative burdens.” 240 Thus, to prevail on a Title II claim for failure to accommodate, a plaintiff must show that she is a qualified individual with a disability who is “denied participation in, or the benefits of, the services, programs, or activities of a public entity because of [her] disability” and that the modifications needed to secure her participation or receipt of benefits are not an undue burden. 241

Section 504 of the Rehabilitation Act makes “essentially the same provision,” 242 though its coverage extends to “programs or activities receiving Federal financial assistance.” 243 Except regarding issues related to this difference in coverage, cases interpreting Title II of the ADA and Section 504 of the Rehabilitation Act are “interchangeable.” 244 Together, these statutes prohibit discrimination against people with disabilities by public entities and recipients of federal funding, including private organizations. 245

The Supreme Court held in Pennsylvania Department of Correction v. Yeskey 246 that “the ADA plainly covers state institutions.” 247 Thus, the ADA applies to “medical services[] and educational and vocational programs” provided to people in the custody of federal or state governments, including “prisoners” and, presumably, people committed to hospitals. 248

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239. Id. § 12131(2).
240. 28 C.F.R. § 35.150(a)(3) (2014). The undue burden inquiry requires a case-by-case assessment that weighs the following nonexclusive factors: “(1) The overall size of the recipient’s program or activity with respect to the number of employees, number and type of facilities, and size of budget; (2) The type of the recipient’s operation, including the composition and structure of the recipient’s workforce; and (3) The nature and cost of the accommodations needed.” Id. § 42.511(c).
243. Id. (quoting 29 U.S.C. § 794(a) (2012)).
244. Gorman, 152 F.3d at 912 (quoting Allison v. Dep’t of Corr., 94 F.3d 494, 497 (8th Cir. 1996)). To prevail on a Section 504 claim, “a plaintiff must demonstrate that: (1) he is a qualified individual with a disability; (2) he was denied the benefits of a program or activity of a public entity which receives federal funds; and (3) he was discriminated against based on his disability.” Id. at 911 (footnote omitted). The Code of Federal Regulations provides that “recipient[s] [of federal financial assistance] shall make reasonable accommodation to the known physical or mental limitations of an otherwise qualified handicapped applicant or employee unless the recipient can demonstrate that the accommodation would impose an undue hardship on the operation of its program.” 28 C.F.R. § 41.53.
247. Id. at 209.
248. See id. (holding that the ADA “unmistakably includes State prisons and prisoners within its coverage”) (internal quotation marks omitted).
In the criminal context, it is clear that once in custody—and for the duration of custody—a person with a disability is entitled to receive reasonable accommodations. It is less clear, however, whether accommodations must be made at the time a person is being taken into custody—for example, during an arrest. Currently, this question is a matter of some disagreement among the circuit courts: the Fifth, Eighth, Ninth, and Eleventh Circuits have allowed ADA claims arising from arrests in at least some circumstances. The Fourth Circuit historically has not, but in a recent about-face, it implied strongly that it might do so on

249. See supra notes 247–48 and accompanying text.

250. See Hainze v. Richards, 207 F.3d 795, 801 (5th Cir. 2000) (holding that although Title II does not apply to officers’ “on-the-street” responses, officers must reasonably accommodate an arrestee’s disability once an area is secure and there is no threat to human safety).

251. See Roberts v. City of Omaha, 723 F.3d 966, 973 (8th Cir. 2013) (“[T]he ADA and the Rehabilitation Act apply to law enforcement officers taking disabled suspects into custody.”); Gorman v. Bartch, 152 F.3d 907, 911–13 (8th Cir. 1998) (holding more narrowly that the ADA applied to the transportation of an arrestee with paraplegia).

252. See Sheehan v. City & Cnty. of S.F., 743 F.3d 1211, 1217 (9th Cir. 2014) (“[W]e join the majority of circuits that have addressed the issue and hold that Title II of the Americans with Disabilities Act applies to arrests.”).

253. See Bircoll v. Miami-Dade Cnty., 480 F.3d 1072, 1084 (11th Cir. 2007) (declining to “enter the circuits’ debate about whether police conduct during an arrest is a program, service, or activity covered by the ADA” because, “[i]n any event, [an arrestee] could still attempt to show an ADA claim under the final clause in the Title II statute: that he was ‘subjected to discrimination’ by a public entity, the police, by reason of his disability.”). As the Ninth Circuit later did in Sheehan, the Eleventh Circuit held in Bircoll that the ADA applies categorically to arrests:

[T]he question is not so much one of the applicability of the ADA because Title II prohibits discrimination by a public entity by reason of [a person’s] disability. The exigent circumstances presented by criminal activity and the already onerous tasks of police on the scene go more to the reasonableness of the requested ADA modification than whether the ADA applies in the first instance.

Id. at 1085. As to the question of under what circumstances accommodation is required, the court explained: “[T]he question is whether, given criminal activity and safety concerns, any modification of police procedures is reasonable before the police physically arrest a criminal suspect, secure the scene, and ensure that there is no threat to the public or officer’s safety.” Id.

254. Compare Sheehan, 743 F.3d at 1217 (“[W]e join the majority of circuits that have addressed the issue and hold that Title II of the Americans with Disabilities Act applies to arrests.”), and Hainze, 207 F.3d at 801 (finding that officers must reasonably accommodate an arrestee’s disability once an area is secure and there is no threat to human safety), and Gohier v. Enright, 186 F.3d 1216, 1221 (10th Cir. 1999) (stating that “a broad rule categorically excluding arrests from the scope of Title II . . . is not the law”), with Rosen v. Montgomery Cnty., 121 F.3d 154, 157 (4th Cir. 1997) (“The most obvious problem is fitting an arrest into the ADA at all.”). See also, e.g., Patrice v. Murphy, 43 F. Supp. 2d 1156, 1160 (W.D. Wash. 1999) (holding that “an arrest is not the type of service, program, or activity from which a disabled person could be excluded or denied the benefits”).
appropriate facts.²⁵⁵ The Sixth²⁵⁶ and Tenth²⁵⁷ Circuits have acknowledged the fray but declined to enter it. Among the circuits that have allowed ADA claims arising from arrests, the Fifth Circuit uses the most stringent standard for determining when Title II applies. In the Fifth Circuit, the obligation to make reasonable accommodations “does not apply to an officer’s on-the-street responses to reported disturbances or other similar incidents, whether or not those calls involve subjects with mental disabilities, prior to the officer’s securing the scene and ensuring that there is no threat to human life.”²⁵⁸ In Sheehan v. City and County of San Francisco,²⁵⁹ decided by the Ninth Circuit last year, the Ninth Circuit joined the Eleventh in embracing a broader standard. Sheehan held that the obligation to make reasonable accommodations applies categorically to arrests and that the presence of exigent circumstances (such as might require an on-the-street response) simply informs the analysis of what accommodations are reasonable.²⁶⁰ The Supreme Court has not yet addressed whether or to what extent Title II applies to arrests, but it is poised to do so. The municipal defendant in Sheehan filed a writ of certiorari, which the Supreme Court granted on November 25, 2014.²⁶¹

Few courts have addressed or even acknowledged the narrower—and meaningfully distinct—question of whether Title II and Section 504 require law enforcement and medical personnel to make reasonable accommodations for people taken into custody under an order of involuntary commitment. As in the criminal-arrest context, there is no question that reasonable accommodations are required once the commitment has been executed and the committed person is in the custody of the state.²⁶² A person who is committed is entitled to reasonable accommodations for the duration of his

²⁵⁵. Compare Rosen, 121 F.3d at 157 (“The most obvious problem is fitting an arrest into the ADA at all.”), with Waller v. City of Danville, 556 F.3d 171, 172–73, 177 n.3 (4th Cir. 2009) (analyzing extensively the reasonableness of making accommodations where, after two hours of negotiations broke down, officers shot and killed a man with mental illness who was holding his girlfriend hostage and concluding that “any duty of reasonable accommodation was met in these circumstances”).

²⁵⁶. See Tucker v. Tennessee, 539 F.3d 526, 536 (6th Cir. 2008) (affirming the district court’s grant of summary judgment because, “even if the arrest were within the ambit of the ADA,” the facts presented did not show a violation). The district court had held categorically that arrests do not fall within the ADA’s ambit; the panel declined to offer guidance. Id. at 530, 536.

²⁵⁷. See Gohier, 186 F.3d at 1221 (clarifying that “a broad rule categorically excluding arrests from the scope of Title II . . . is not the law” and that the issue of when, if ever, the ADA applies to arrests “remains an open question in this circuit”).

²⁵⁸. Hainze, 207 F.3d at 801; see also id. at 802 (“Once the area was secure and there was no threat to human safety, the Williamson County Sheriff’s deputies would have been under a duty to reasonably accommodate Hainze’s disability in handling and transporting him to a mental health facility.”).

²⁵⁹. 743 F.3d 1211 (9th Cir. 2014).

²⁶⁰. Id. at 1231–32 (quoting Bircoll v. Miami-Dade Cnty., 480 F.3d 1072, 1085 (11th Cir. 2007)).


²⁶². See supra notes 247–48 and accompanying text.
confinement.\textsuperscript{263} As in the criminal-arrest context, however, courts have reached different conclusions—and in some cases have reached the same conclusion by different lines of reasoning—as to whether reasonable accommodations must be made at the time a commitment order is being executed.\textsuperscript{264}

Courts answering this question in the affirmative have emphasized the statutory history and remedial nature of the ADA,\textsuperscript{265} as well as the practical consideration that authorities may obtain compliance more readily when they demonstrate “sensitivity to human rights.”\textsuperscript{266} Courts answering it in the negative, on the other hand, have expressed concern that recognizing failure-to-accommodate claims in this context would imperil law enforcement and medical personnel\textsuperscript{267} and “convert every involuntary commitment transport into a civil rights violation.”\textsuperscript{268} This concern seems misplaced, however, because Title II requires modifications only when they are reasonable—this is, when the burden they would impose on the service provider is not “undue.” Troublingly, courts and commentators have tended to analyze accommodation in the commitment context in the same way as in the arrest context,\textsuperscript{269} even though these contexts—while analogous to the extent they involve gaining custody of a person against her will—are vastly different in several critical respects. This lumping together of commitment and arrest is unfortunate because, on the whole, the rationale for requiring accommodation in the commitment context is considerably stronger than in the arrest context. The Supreme Court should keep in mind the important distinctions between these contexts when it considers the scope of the ADA’s protections in \textit{Sheehan}.


\textsuperscript{264} Compare \textit{Schorr v. Borough of Lemoyne}, 243 F. Supp. 2d 232, 235–36, 239 (M.D. Pa. 2003) (relying on the statutory history and remedial nature of the ADA in recognizing a claim for failure to modify police practices to accommodate people with mental illness who are subject to involuntary commitment warrants), and \textit{City of Newark v. J.S.}, 652 A.2d 265, 276 (N.J. Super. Ct. Law Div. 1993) (“Compliance is more likely when authorities demonstrate sensitivity to human rights.”), with \textit{Estate of Awkward v. Willingboro Police Dep’t}, No. 07-5083(NLH), 2010 WL 3906785, at *13 (D.N.J. Sept. 30, 2010) (holding that officers’ conduct in using deadly force to subdue a mentally ill person who resisted the execution of an involuntary commitment order “cannot serve as a basis for an ADA . . . violation for disability discrimination because such a finding would convert every involuntary commitment transport into a civil rights violation”). \textit{See also supra} notes 244–51.

\textsuperscript{265} E.g., \textit{Schorr}, 243 F. Supp. 2d at 235–36, 238–39.

\textsuperscript{266} \textit{City of Newark}, 652 A.2d at 276.

\textsuperscript{267} See, e.g., \textit{Hainze v. Richards}, 207 F.3d 795, 801 (5th Cir. 2000) (“To require the officers to factor in whether their actions are going to comply with the ADA, in the presence of exigent circumstances and prior to securing the safety of themselves, other officers, and nearby civilians, would pose an unnecessary risk to innocents.”).

\textsuperscript{268} \textit{Awkward}, 2010 WL 3906785, at *13.

\textsuperscript{269} Cf. \textit{Sheehan v. City & Cnty. of S.F.}, 743 F.3d 1211, 1232 (9th Cir. 2014) (“[E]xigent circumstances inform the reasonableness analysis under the ADA, just as they inform the distinct reasonableness analysis under the Fourth Amendment.”).
First, unlike arrests, commitments always involve a person who is disabled under the ADA. Because of this, law enforcement and medical personnel called upon to execute a commitment order know in advance that the person with whom they will engage has (or is regarded as having) a mental disability, and they can prepare to modify their procedures accordingly. This superior notice, and the opportunity it affords service providers to prepare to make reasonable accommodations, creates a greater moral obligation to actually make them. This is perhaps why even the circuits most reluctant to apply the ADA to arrests nonetheless have held that whenever police have sufficient time and information to deliberately plan and execute a criminal arrest—that is, so long as the arrest is not an on-the-street response—they must make reasonable accommodations.

Indeed, the superior notice that marks the commitment context may change what constitutes an “undue burden” because improved notice of the need to make a modification necessarily reduces the burden of making it. Moreover, since the ADA may apply to the commitment decision itself, there is no reason it should not also apply to every subsequent part of the commitment “service,” including the execution of the commitment order. That it might not do so defies logic.

Second, a person under arrest is suspected of having committed a crime, whereas a person being committed is typically suspected only of the potential to commit some (often unspecified) future dangerous act that, even if it occurs, may not constitute a crime. A criminal suspect is thus differently culpable than a person being committed (even assuming he is in fact dangerous on account of mental illness), who may have no culpability whatsoever—at least according to the normative judgments of our criminal law and, I would contend, most people. For these reasons, criminal arrest and civil commitment involve significant functional and moral differences that make the arguments for requiring reasonable modifications in the commitment context considerably stronger than in the arrest context.

The advance notice of the need to make reasonable accommodations that is available to people executing commitment orders, and the non-culpable mental state of the people with disabilities they engage, counsel strongly for the recognition of ADA failure-to-accommodate claims arising from the execution of involuntary commitment orders. Enforcing the ADA’s reasonable accommodation requirements at the time the commitment order is executed—consistent with the statute’s recognized applicability to all other aspects of the commitment process—would encourage peaceful cooperation on the part of people being committed by respecting their dignity and demonstrating sensitivity to their needs. Moreover, it would help further the

270. This is because people who are committed are by definition either disabled or regarded as such.
271. Hainze, 207 F.3d at 801.
272. For example, when a person harms herself.
remedial purpose of the ADA and make involuntary commitment safer and more humane for all involved.

V. Conclusion

Commitment entails a profound loss of civil rights and opportunity—both during the period of confinement and afterward, long after a person has reentered the community. Because of this, normative conceptions of justice suggest a moral imperative to ensure the commitment process is fair and free from discrimination. People facing commitment deserve a fair shake: they deserve access to independent experts; the right to have dangerousness shown by proof of an overt act; the right to sue when stereotypes or prejudice infect the decision process; and the right to a safe commitment that reasonably accommodates their disability.

But we need not rely on abstract notions of justice alone as reason to ensure the integrity of the commitment process. There also is an important practical reason. Commitment is intended to promote therapeutic outcomes: it is supposed to help people with mental illness. Yet studies show that the often-traumatic experience of being committed can inflict severe psychological harm. This possibility is at its zenith when a commitment hearing is a pro forma proceeding whose outcome is all but predetermined, compromising bedrock values such as dignity, trust (in doctors, lawyers, and the state), and equal citizenship. And because people with mental illness are, as a group, chronic victims of discrimination, those facing commitment may be especially sensitive to threats to their status as full and equal shareholders in our justice system.

There is psychological value in participating in a hearing where one’s voice is respected and given careful consideration, not automatically discounted as irrational or crazy. When procedural justice is done, an adverse outcome is more difficult to dismiss as the result of psychiatric railroading. At the same time, a psychiatrist who is at risk of losing at the commitment hearing may be more likely to work to cultivate a positive relationship with the patient that, besides giving the patient reason to consent to voluntary treatment, may itself have intrinsic therapeutic value. Perhaps most important, having one’s voice heard is empowering—it nurtures the will and inspires self-confidence and, with it, a sense of possibility. As law professor Elyn Saks recalled in her bestselling memoir about her own struggle with schizophrenia: “Even at my craziest, I interpreted [having a say in my treatment] as a demonstration of respect. When you’re really crazy, respect

273. See Winick, supra note 53, at 38 (noting the potential “antitherapeutic consequences” of the commitment process).

274. Id. at 41 (“In practice, commitment hearings tend to be brief and non-adversarial episodes in which judges appear to ‘rubber stamp’ the recommendations of clinical expert witnesses.”). Justice Warren Burger used more evocative language in writing that commitment hearings for minor children whose parents sought to have them committed should not simply be “time-consuming procedural minuets before the [child’s] admission.” Parham v. J. R., 442 U.S. 584, 605 (1979).
is like a lifeline someone’s throwing you. Catch this and maybe you won’t drown.”

A client I helped represent in a commitment hearing at the Austin State Hospital in Travis County, Texas, found himself in a precarious position when, during his cross-examination by the state’s attorney, he denied that he had a mental illness yet agreed to take psychotropic medication if he were discharged and not committed. (Whether a person diagnosed with a serious mental illness will take medication outside the hospital setting often informs the judicial calculus.) The state’s attorney quickly boxed him in: “If you’re not mentally ill,” she asked, “then why would you agree to take medication?” His response spoke volumes. Pointing his finger as though to simulate an accusation, he responded that the medication helped him feel better but that he just didn’t like being told, “You’re mentally ill.” For many people, understandably, being treated with dignity is a precondition for being treated at all.

—David D. Doak

275. SAKS, supra note 10, at 80; see also id. at 130 (“I was going to the hospital for the third time, I knew it. I was going to be an inpatient again, and they would make me take drugs. Every nerve in my body was screaming. I didn’t want a hospital. I didn’t want drugs. I just wanted help.”).

276. Pursuant to Texas’s student-practice rule, law students who participate in The University of Texas School of Law’s Mental Health Clinic represent proposed patients in commitment hearings and related proceedings in Travis County Probate Court under the supervision of an attorney. TEX. RULES AND REGULATIONS GOVERN. THE PARTICIPATION OF QUALIFIED LAW STUDENTS AND QUALIFIED UNLICENSED LAW SCHOOL GRADUATES IN THE TRIAL OF CASES IN TEXAS R. II (West 2014).

277. Churgin, supra note 162; see also, e.g., Johnstone v. State, 961 S.W.2d 385, 391 (Tex. App.—Houston [1st Dist.] 1997, no writ) (Nuchia, J., dissenting) (opining that continuous refusal to take prescribed medication should alone satisfy the overt act requirement necessary to meet the commitment standard).