ADMINISTRATIVE CIVIL COMMITMENT: THE NEBRASKA EXPERIENCE AND LEGISLATIVE REFORM UNDER THE NEBRASKA MENTAL HEALTH COMMITMENT ACT OF 1976†

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INTRODUCTION

For many years the standards and procedures for the commitment of the mentally ill have reflected the view that the commitment process should be a scientific determination which is best made by trained medical personnel. The use of formal judicial proceedings and "criminal" due process procedural safeguards in a mental health context was considered to be detrimental to the proposed patient's welfare and to the decisionmaking process. Based upon these views, many states established relaxed judicial proceedings for the commitment of the mentally ill while others, such as Nebraska, vested civil commitment authority in non-judicial administrative boards of mental health.¹

During the past decade, however, a widespread attack has been mounted on these mental health commitment procedures and on

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¹ Prior to their revision in 1976, Nebraska statutes empowered local administrative boards of mental health to commit persons who were "mentally ill" and in need of hospitalization to state mental hospitals for an observation period not to exceed sixty days. The process was initiated
the appropriateness of involuntary commitment itself. Underlying this attack has been the belief by many critics that broad commitment categories and relatively informal commitment procedures presented too great a danger for abuse and error. These critics have questioned the ability of psychiatrists and other mental health professionals to identify and treat "mentally ill" persons. The entire commitment process has been viewed by many as involving potential life-long deprivation of many of the patient's most basic civil rights; placement in mental institutions which were often overcrowded, dangerous, poorly maintained, and inadequately staffed; treatment which the patient might not be able to refuse; invasion of the patient's privacy; stigmatization of the patient; and alienation from society.

This concerted attack on civil commitment revived a long-standing debate among lawyers, mental health professionals, legislators, and others concerning to what extent and by what procedures the law should allow the imposition of involuntary medical treatment or custodial care for the purpose of either helping a mentally ill person or protecting society from that person. The criticism of the commitment process led to litigation based upon a variety of constitutional grounds and to proposals for legislative reform. The basic issues centered on the substantive standards for commitment, the proper allocation of decisionmaking authority, the extent of notice that a proposed patient should be given, the

by the filing of an application. If it decided that sufficient grounds existed to proceed, the board was authorized to issue an arrest warrant and to appoint a physician to examine the proposed patient. The examining physician reported to the board the results of his examination and a final hearing was held. Once a patient was hospitalized, the hospital superintendent was charged with evaluating whether that person was mentally ill and in need of extended hospitalization. If he so certified, commitment for an indefinite period was complete. Neb. Rev. Stat. §§ 83-325, -328 (Reissue 1971) (repealed 1976).

Dean Shaffer candidly pointed out this attack on civil commitment: "These authors—lawyers, social scientists, scholars, psychiatrists, and students—have a target in their sights, and they are not out primarily to analyze the target; they are out to destroy it." Shaffer, Introduction to Symposium: Mental Illness, the Law and Civil Liberties, 13 Santa Clara Law. 369 (1973).

appropriateness of the proposed patient's presence at commitment proceedings, the appropriate standard of proof and other evidentiary issues, and the proper role of medical experts and legal counsel in the decisionmaking process. Opponents generally have been successful in limiting the scope of commitment to mentally ill dangerous persons and in establishing several "criminal" due process safeguards as constitutional requirements.\(^4\)

The Nebraska experience under its commitment statutes in many respects presents a microcosm of these general developments in civil commitment law. In 1975, the attack on involuntary commitment in Nebraska culminated in a three-judge federal court decision declaring several provisions of the Nebraska law unconstitutional because it failed to provide constitutionally sufficient commitment standards and adequate procedural safeguards.\(^5\) In response to this decision and continuing criticism, the Nebraska Legislature subsequently enacted the Nebraska Mental Health


5. The court declared unconstitutional NEB. REV. STAT. §§ 83-325, -328 (Reissue 1971) and § 83-306(4) (Cum. Supp. 1974). The court held that due process and equal protection permitted only those persons who are mentally ill and pose a serious threat of substantial harm to themselves or others to be committed. This threat of harm had to be evidenced by a recent overt act or threat. Noting the uncertainties of diagnosis of mental illness and of its treatment, the court stated that to permit involuntary commitment upon a finding of "mental illness" and the need for treatment alone would be tantamount to condoning the state's commitment of persons deemed socially undesirable for the purpose of indoctrination or conforming the individual's beliefs to the beliefs of the state.

The court found that the statutory scheme failed to require effective and timely notice of the "charges" under which a person is alleged to be a proper subject for involuntary commitment as well as adequate notice of all other rights. It also failed to set maximum time limits on the commitment process and to insure the proposed patient the right to be present at the hearing, to be free from involuntary drugs or other treatment, and to have the assistance of counsel at all hearings on his commitment.

The statutes were also found to be constitutionally defective in that they failed to insure the right to confront and to cross-examine witnesses, to allow the proposed patient to present witnesses on his own behalf at the final hearing, and to require a separation of functions so as to guarantee an impartial tribunal by insuring that the examining physician not vote in the commitment decision. The court, however, rejected the plaintiffs' contention that due process required the final commitment hearing to be "judicial" rather than "administrative" and that a jury trial was constitutionally required. Doremus v. Farrell, 407 F. Supp. 509, 514-17 (D. Neb. 1975).
Commitment Act of 1976,\(^6\) which substantially narrowed the persons eligible for commitment and extended additional due process safeguards to commitment proceedings. The revised law, however, retained an administrative approach to civil commitment decision-making.

This article examines several reoccurring issues raised in the debate over civil commitment. In particular, it considers what procedural safeguards must be included in a commitment scheme to meet current minimum constitutional requirements and discusses the appropriateness of including other procedural safeguards as a matter of legislative policy. It examines the difficulties of making procedural rights effective in actual practice when the person to be protected may be mentally ill, the problems of designing procedures to reduce possible abuses without concurrently discouraging legitimate use of the system, and the difficulties of designing a system to function well in both urban and rural settings which vary widely in available professional skills and services, case loads, and types of disorders that occur. It also evaluates the extent to which the new Nebraska legislation eliminates problems experienced under prior commitment law and suggests further improvements.

The discussion of these issues and the general suggestions for statutory reform made in this article draw upon a twelve month empirical study of the commitment process in Nebraska.\(^7\) Although most of the legislative suggestions and observations are based upon an analysis of Nebraska's experiences under its administrative system of commitment, it should be pointed out that many of those suggestions and observations are applicable to "judicial" commitment systems in other states as well.

**BASIC CONSTITUTIONAL AND STATUTORY PROCEDURAL SAFEGUARDS**

One purpose of procedural due process safeguards in commitment proceedings is to help assure fair and accurate judgments when the commitment process is initiated in good faith. Another purpose is to help prevent abuse of the commitment process by those acting in bad faith, which is commonly referred to as "rail-

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\(^7\) The study of mental health commitments in eastern Nebraska, conducted from July 1975 through June 1976, involved data collection from mental health boards, district court and juvenile court records, direct observation of commitment proceedings, and interviews with members of county boards of mental health, judges, psychiatrists, and others from a five-county area. The scope of the study included civil commitment, incompe-
roading." Railroading in this context can be motivated by financial gain, personal vendettas, the desire to be rid of socially unwanted persons or troublesome criminal defendants, or political reasons.

Current statutory commitment procedures are generally based upon varying combinations of four different procedural models. One is the "criminal law" model, with its traditional adversarial aspects, its high standard of proof, probable cause hearings, strict rules of evidence, and right to a jury trial. A second model is the "medical" model, which emphasizes informality, use of "non-criminal" terminology, decisionmaking by doctors and hospital personnel, and avoidance of formal legal procedures unless the patient or others protest or otherwise request them. A third procedural model is a "civil" model, which generally preserves the right to a jury trial as it existed at common law, uses a "preponderance of the evidence" standard of proof, permits involuntary physical and mental examinations, and does not recognize a privilege against self-incrimination. A fourth procedural model is an "administrative" model, in which an administrative board makes findings of facts and conclusions of law. The board may perform investigative functions, and its decisions may be subject to varying standards of review.

8. Potential wrongful commitments may involve "[t]he classic example [of] the unscrupulous person moving to have a rich relative or business associate committed in order to get his money. . . ." Curran, Hospitalization of the Mentally Ill, 31 N.C.L. REV. 274, 293 (1953).
9. One reason sane persons might be "railroaded" into a mental institution is that they are simply unwanted; perhaps the best example is the elderly. Id. at 294. Another reason is that personal disputes may motivate commitment for vindictive purposes. See Note, Commitment of the Mentally Ill in Ohio, 12 W. Res. L. Rev. 596 (1961) (examples of abuses in situations of pending divorces and neighborhood feuds). See also Administrative Civil Commitment, supra note 7, at 280.
12. This medical model is typified by medical certification wherein the opinion of qualified physicians is sufficient to authorize admission to a mental facility. See AMERICAN BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW 57-59 (rev. ed. S. Brakel & R. Rock 1971) [hereinafter cited as ABF STUDY].
From a constitutional point of view, procedural due process does not require any one particular procedure so long as the essential aspects of fairness are maintained. Those aspects include a requirement of notice of the proceedings and of one's rights in some form, a requirement of a hearing or some other form of determination of the propriety of the commitment, the right to have assistance of counsel, the right to have evidence presented on one's behalf, and the right to have the commitment decision be made by an impartial tribunal. Present statutory commitment schemes include these basic procedural rights in some form, and there appears to be little doubt that these rights are minimal constitutional standards. In relation to these rights, the legal question is whether the particular procedure adopted by the state adequately provided them and whether the statutory procedure was complied with in a particular case.

Whether other procedural rights and evidentiary rules, such as a privilege against self-incrimination, exclusion of hearsay, trial by jury, cross-examination, and mandatory representation of the proposed patient by counsel, are constitutionally required to assure fairness is unclear. Lower court decisions, as discussed in subsequent sections of this article, vary on the extent to which these particular rights are constitutionally mandatory. Some states establish them as a matter of statutory policy, although many do not. For example, under the recently enacted Nebraska legislation, hearsay is inadmissible and the proposed patient is given the right to confront and cross-examine witnesses; on the other hand,

15. See generally Developments, supra note 3, at 1271-1316.
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representation by counsel is not mandatory and the proposed patient is denied a jury trial.18

NOTICE, PRESENCE AT HEARINGS, AND TIME LIMITS

The debate and litigation over the extent to which procedural safeguards are necessary in commitment proceedings and the particular form those safeguards should take parallels a similar development that occurred in relation to procedural rights in juvenile court proceedings. In In re Gault the Supreme Court held that even when a state is acting under its parens patriae power in a civil juvenile court proceeding, basic due process procedural safeguards must be provided when the juvenile's fundamental right to liberty is at stake.19 On the other hand, the Court in McKeiver v. Pennsylvania found that a jury trial was not constitutionally required in juvenile proceedings since such a requirement would impair the state's interest in informality by making the proceeding fully adversarial, introducing delay, and impeding experimentation with new procedures.20

Those who favor relaxed safeguards in involuntary commitment proceedings would add other state interests in addition to those mentioned by the Court in McKeiver. It is argued that certain procedural safeguards, such as mandatory notice of the proceedings and presence at hearings, for example, can cause psychological harm to the proposed patient,21 provoke acts of violence,22 discourage family members from coming forward to secure early treatment,23 and alienate the proposed patient from

22. Weihofen, supra note 21, at 847-48. If the court does not commit a paranoic person because it fails to appreciate the seriousness of his disorder or for any other reason, he “may attempt to kill those who have thus ‘betrayed’ him.” Id. at 848.
23. Id. at 848-49. See also Note, Constitutionality of Nonjudicial Confinement, 3 Stanf. L. Rev. 109, 110 (1950), which relates that “[t]he resulting stigma and accompanying publicity [of judicial commitments] discourage early resort to hospitalization by the patient or his family.”
his family and friends who testify "against" him. It is thus claimed that a "system containing more of the elements of a scientific determination, with as little resort to adversary process as possible, would . . . offer more real protection from 'railroading.' . . . The most effective procedural safeguard would not be notice and presence, but a requirement that the investigation be exhaustive, searching out all relevant facts . . . .”

The impact of notice is sought to be lessened in several ways by those favoring relaxed safeguards, depending upon the particular statutory scheme or local policy. Informal, word-of-mouth notice is permitted in some states when formal notice would be detrimental in a physician's opinion. Some statutes allow substituted notice on the proposed patient's friends or family. Also, the contents of the notice may be limited to the date, place, and time of the proceeding; by withholding other details, the traumatization is supposedly decreased.

Proponents of a "full" notice requirement, on the other hand, argue that the purpose of a detailed notice is to allow a person to prepare a defense by securing counsel and arranging for witnesses on his behalf prior to the hearing. If notice to the proposed patient would likely provoke violent acts, more summary emergency procedures would probably be used anyway. Proponents also point out that a person not receiving a detailed notice will probably suffer trauma from being detained in a hospital without knowing why and not being advised of what he may do about it. Detailed notice may thus serve the purpose, it is argued, of

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24. In interviews with mental health professionals involved in the civil commitment process in Nebraska, concern was expressed that mandatory presence at hearings would have harmful effects upon future therapy and the doctor-patient relationship. This concern was particularly directed at those situations where the mental health professional testifying against the proposed patient would also be directly involved in treating him. Perhaps a partial answer to this objection might be to keep the treatment process as separate as possible from the commitment process.

25. Mental Health Legislation, supra note 21, at 107 (footnotes omitted).

26. Id. at 107 n.44.

27. See Weihofen, supra note 21, at 845.

28. Cf. Extension of "Criminal" Safeguards, supra note 4, at 264. This view has been characterized as the "vegetable theory" of civil rights of mentally ill persons, i.e., the mental state of proposed patients is such that they "could not be deprived of any rights [they] might possess because [they] are not capable of understanding [they] possessed those rights in the first place." Id. at 259.

providing a concerned individual with information needed to facilitate his understanding and to exert some influence on the proceeding.\textsuperscript{30}

Perhaps many of the objections to "full" notice could be met by having the notice contain a non-legalistic explanation of the details of the impending proceedings and a statement of the proposed patient's rights and other pertinent information to the extent that it is available. If the commitment is a non-emergency one, the notice could be served by a mental health professional, if one is available, rather than a peace officer.\textsuperscript{31} If it is an emergency commitment, the proposed patient could receive this detailed notice at the place where he is held for observation.\textsuperscript{32}

Prior to 1976, Nebraska statutes did not require that a proposed patient be given notice that an application had been filed and that the board of mental health was considering commitment.\textsuperscript{33} In many cases the person discovered that commitment was pending only when he was picked up by the sheriff.\textsuperscript{34} The entire commitment process was often conducted in such a way that meaningful preparation of a defense was impossible. For example, in some rural counties, a person was filed upon, picked up, examined before the board of mental health, and sent to the state hospital all within the same day.\textsuperscript{35} Furthermore, the appearance of the information and warrant of arrest in some counties gave the impression that the issue of the person's sanity had already been decided, particularly since the information and warrant did not explain the commitment process.\textsuperscript{36}

\begin{itemize}
  \item \textsuperscript{30} Extension of "Criminal" Safeguards, supra note 4, at 264.
  \item \textsuperscript{34} See generally note 1 supra and Administrative Civil Commitment, supra note 7, at 269-75 (explanation of the commitment procedures in Nebraska prior to 1976).
  \item \textsuperscript{35} See Administrative Civil Commitment, supra note 7, at 273 n.38.
  \item \textsuperscript{36} For example, one county studied in eastern Nebraska used information and arrest forms that had in bold print on their face, "Adjudged Mentally Ill." Other counties used the phrase, "Charged with Mental Illness." The captions of these and other forms have been redrafted under the 1976 legislation to read: "In the Interest of ——, Alleged to be a Mentally Ill Dangerous Person." Neb. Rev. Stat. § 83-1026 (Cum. Supp. 1976).
\end{itemize}
The three-judge federal court which considered this procedure found that it failed to provide adequate and effective notice of the commitment proceedings, the reasons for detention, and the rights to which the proposed patient was entitled. Specifically, the court held that prior to the preliminary inquiry for emergency detention, the proposed patient must be informed of the reasons and necessity for emergency detention, and time and location of the hearing, and the right to counsel. Prior to the final hearing, a notice containing the time and location of the hearing, the reasons for detention, and the standards for commitment, as well as the petition itself, must be served sufficiently in advance of the hearing to permit preparation.

The Nebraska Mental Health Commitment Act of 1976 reflects the notice requirements mandated by the federal court decision. Under this act, the proposed patient receives notice of the time and place of the hearing, a list of all rights which he is accorded, and a copy of the petition which includes a description of the behavior on which the petition is based. If the immediate custody of the proposed patient is not required, the notice also includes the names, addresses, and telephone numbers of the mental health professionals in his locale by whom he may be evaluated prior to the hearing.

Nebraska law prior to 1976 provided that if the board "decide[s] that the presence of the proposed patient . . . would probably be injurious to him, the board members shall not require [his presence] at the hearing on the application." Under this provision,

38. Neb. Rev. Stat. §§ 83-1025, -1027, -1028 (Cum. Supp. 1976). At the commencement of the preliminary hearing, the board is statutorily required to ask whether the proposed patient has received a copy of the petition and a list of his rights and whether he has read and understood them. If he has not, the board must explain to him any part he has not read or understood. Neb. Rev. Stat. §§ 83-1031, -1035 (Cum. Supp. 1976).
40. Neb. Rev. Stat. § 83-325 (Reissue 1971) (repealed 1976). This provision is based on the same grounds that are used to support limited or substitute notice, viz., the proposed patient’s exposure to testimony against him at hearings would be traumatic and psychologically harmful to him. See text accompanying notes 21-24 supra; Coli v. Hyland, 411 F. Supp. 905 (D.N.J. 1976). “In a proceeding designed at least in part to benefit the patient, it would be indeed a paradox to require him to hear testimony which might adversely affect his mental condition.” Id. at 913. It should be pointed out, however, that presence at hearings allows a proposed patient to react to and dispute testimony offered. This safeguard may be quite im-
for example, one urban Nebraska county routinely excluded proposed patients. The entire board of mental health in that county thus rarely saw a proposed patient; it did so only when a person presented himself for commitment or in rare instances when an attorney demanded the proposed patient's presence.\textsuperscript{41}

The Nebraska federal court held that a proposed patient has a constitutional right to be present at hearings and to confront and cross-examine witnesses. Exclusion of the proposed patient on the grounds that his presence would be unnecessary or injurious to him was held to be an unconstitutional limitation of those rights.\textsuperscript{42} The court also held that "the subject [has] the right to be free from involuntary drugs or other treatment which might dilute or destroy his ability to assist in the presentation of his defense."\textsuperscript{43} The new Nebraska legislation specifically provides that the proposed patient "shall appear personally [and] shall have the right to . . . cross-examine adverse witnesses."\textsuperscript{44} It also limits the quantities of medication or other treatment which can be given prior to any hearing.\textsuperscript{45}

The earlier Nebraska statutory scheme permitted a proposed patient to be detained for examination and investigation and only required the board to meet "as soon as practicable" after the filing of the examining physician's certificate.\textsuperscript{46} The federal court decision and the new legislation now require that a preliminary inquiry

\textsuperscript{41} One of the four rural counties studied routinely excluded the proposed patient from hearings. The other three rural counties usually allowed the proposed patient to be present during the inquiry. In the latter counties, the examination by the doctor usually occurred at the hearing itself.

\textsuperscript{42} Doremus v. Farrell, 407 F. Supp. 509, 515 (D. Neb. 1975). The proposed patient must also be given the opportunity to present evidence in his own behalf and to compel the attendance of witnesses during the final hearing. \textit{Id.} at 515-16.


\textsuperscript{44} NEB. REV. STAT. §§ 83-1056, -1058 (Cum. Supp. 1976).

\textsuperscript{45} Section 83-1062 provides that the proposed patient "shall not be subjected to such quantities of medication . . . prior to any hearing . . . [which] will substantially impair his . . . ability to assist in his . . . defense at such hearing." NEB. REV. STAT. § 83-1062 (Cum. Supp. 1976) (emphasis added). It is unclear whether this provision sufficiently complies with the federal decision's holding which recognizes a "right to be free from involuntary drugs . . . which \textit{might dilute or destroy} his ability . . . ." Doremus v. Farrell, 407 F. Supp. 509, 515 (D. Neb. 1975) (emphasis added).

be held within five days to establish probable cause after emergency
detention and a final hearing within fourteen days after the
preliminary inquiry. 47

STANDARD OF PROOF, RULES OF EVIDENCE
AND SELF-INCRIMINATION

In juvenile proceedings, the Supreme Court has found that
proof beyond a reasonable doubt is constitutionally required to
deprive a juvenile of his fundamental liberties. 48 While some
courts have similarly required proof beyond a reasonable doubt in
civil commitment proceedings, 49 others have found that such a
burden is too demanding on the state. 50 One reason that is offered
against the higher standard of proof is that "mental illness" is not
subject to precise proof as compared to proof of a person's prior
acts in a criminal trial. 51 Pre-1976 Nebraska commitment law did
not specify the standard of proof to be used by the boards in their
commitment decisions. In accord with the Nebraska federal court
decision, 52 the new Nebraska legislation now specifies that clear
and convincing proof must be shown. 53

hearing to be held within 48 hours, if possible, but in any event no later
Unlike prior law, the new legislation also specifically establishes a proce-
dure for emergency detention by peace officers. The proposed patient must
be examined as soon as reasonably possible after his admission to the men-
tal health center or hospital (but not later than 36 hours). The county at-
torney has 24 hours after receiving the examining mental health profes-
sional's report to initiate commitment proceedings. Neb. Rev. Stat. §§ 83-


49. See, e.g., In re Ballay, 482 F.2d 648 (D.C. Cir. 1973) (an extensive
discussion by Circuit Judge Tamm examines the requirement of proof be-
yond a reasonable doubt). See generally Extension of "Criminal" Safe-
guards, supra note 4, at 287-88; Developments, supra note 3, at 1295-1303.

1975) (clear and convincing evidence); Christiansen v. Weston, 36 Ariz. 200,
210, 284 P. 149, 153 (1930) (preponderance of the evidence).

51. See, e.g., In re Levias, 83 Wash. 2d 253, 256, 517 P.2d 588, 590
(1973), which applied a "clear, cogent, and convincing" standard, sugest-
ing it to be the civil equivalent of the criminal standard of beyond a reasonable
doubt.

52. "Given the relatively undeveloped state of psychiatry, proof be-
yond a reasonable doubt is too stringent a standard. The 'clear and con-
vincing' evidence standard would not be impracticable and is required be-
cause of the . . . forced confinement and finding of mental illness." Dore-

The question of admission of hearsay evidence and the use of formal rules of evidence in a commitment proceeding turns on a balancing of the extent to which such a requirement would impair the state's interest in informality against the likelihood of a proposed patient receiving a fair hearing without such rules. Formal rules of evidence would seem to be more important when a jury is used in a commitment proceeding or when non-legally trained decisionmakers are involved since laymen may be particularly unaware of the dangers of hearsay. Likewise, such rules may be more important in an urban context where the committing authority often lacks personal knowledge of the circumstances of the case. On the other hand, required use of formal rules of evidence may substantially impinge on the state's choice of forum since it would be difficult for a committing authority to make formal rulings without legal membership, e.g., a panel of mental health professionals. Furthermore, the use of such rules may be difficult without someone serving in a prosecutorial capacity, a situation which the state may wish to avoid because of its association with criminal proceedings. The Nebraska federal court resolved these conflicting considerations in favor of a requirement of exclusion of evidence in civil commitment proceedings which would be inadmissible in criminal trials. This standard has been incorporated in the new Nebraska legislation.

The Nebraska federal court did not directly consider whether a proposed patient may assert a privilege against self-incrimination nor was that right specifically dealt with in the 1976 Nebraska legislation. However, the availability of this privilege may be implicit in the statutory proscription of the consideration of evidence in commitment proceedings which would be inadmissible in criminal trials.

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54. Cf. text at note 20 supra.
56. It should be noted that the importance of hearsay problems may be minimized to some extent by the fact that much of the potential hearsay testimony would be allowed within the exceptions to the rule. It has also been suggested that hearsay may be admissible at the disposition stage in any event. See Comment, Progress in Involuntary Commitment, 49 Wash. L. Rev. 617, 639-40 (1974).
In any event, some courts have held that a state may not commit a proposed patient “on the basis (in whole or in part) of his statements to examining psychiatrists (or others) in the absence of a showing that the statements were made voluntarily after [he] was informed of and understood the purpose of the examination and that he was not obliged to speak.”

LESS RESTRICTIVE PLACEMENTS

Under pre-1976 Nebraska commitment law, one problem which the boards of mental health faced was the lack of flexibility in case disposition. The Nebraska statutes required the board to either send a proposed patient to a state mental hospital or release him. By statute, the boards were frustrated in their ability to use local facilities, specialized private care facilities (especially for alcoholics), and outpatient care under a “probation” system. Their response in several instances was to overlook the “binary” statutory system and to develop their own network of dispositional alternatives. While it may have improved care and “cure” rates, this development was also extra-legal and erratically utilized.

The new Nebraska legislation substantially expands the boards' authorized dispositional alternatives to include “outpatient treatment, consultation, chemotherapy, or any other program or set of conditions.” The proceedings may also be suspended up to ninety days to determine the results of voluntary treatment alternatives. Throughout the commitment process, the boards are required to pursue alternatives which impose the least restraint upon the proposed patient's liberty consistent with the prevention of harm and successful treatment. In addition, the boards are authorized to conduct a predisposition investigation aided by other agencies.

“ADMINISTRATIVE” VERSUS “JUDICIAL” COMMITMENT

In the recent Nebraska litigation, the plaintiffs contended that due process required the final commitment hearing to be a judicial

59. Section 83-1059 provides that “[i]n no event shall evidence be considered which is inadmissible in criminal proceedings.”
62. See Administrative Civil Commitment, supra note 7, at 275, 281.
64. Id. at §§ 83-1032 to 1036.
65. Id. at §§ 83-1033 to 1040.
66. Id. at §83-1040.
rather than an administrative determination. The court rejected this challenge and thus it seems clear that a state may constitutionally choose between a judicial or non-judicial system, assuming other constitutionally-required procedural safeguards are provided. The choice between these different types of commitment systems reflects basic policy judgments concerning the relative abilities of possible decisionmakers—medical personnel, judges, juries, and others—to make sound commitment decisions.

Because of their training in evaluating the probative value of certain types of evidence and in adversarial techniques such as the art of cross-examination, judges and lawyers are probably better qualified than others to explore disputed factual claims, e.g., whether or not a threat to kill someone was in fact made or whether or not certain alleged conduct actually took place. If formal rules of evidence are used in a commitment proceeding, lawyers and judges would seem to be best qualified to make determinations of admissibility, e.g., whether or not hearsay should be admitted because it falls within one of the many exceptions to that rule. Also, because of their familiarity with different standards of proof, they would seem more able than others to evaluate whether a particular standard of proof has been met.

Commitment decisions involve an evaluation of the proposed patient’s present condition. Sometimes his condition or mental state will be obvious to laymen, e.g., if the person is clearly intoxicated or hallucinating. Sometimes, however, a person’s mental state or present condition may be unclear. In that event, a physician or psychiatrist would seem better qualified than others to attribute the cause of the proposed patient’s present condition to physical causes, such as a brain tumor, ingestion of drugs or alcohol, etc. Likewise, by experience and training, mental health professionals may be more capable than others to describe a person’s mental state or condition through a systematic examination, e.g., that the person is depressed, is exhibiting catatonic behavior, or has delusions.

68. Id. Civil commitment procedures have generally been classified according to the primary authority that makes the commitment decision: judicial or non-judicial. The non-judicial category has been further subdivided into administrative commitment and medical certification. See ABF Study, supra note 12, at 41-42.
69. See A. Brooks, Law, Psychiatry and the Mental Health System 22 (1974) [hereinafter cited as Brooks].
70. Id. at 23-26 (explanation of mental status examination). Of course, actual practice may fall far short of the thorough examination envisioned by the theoretically ideal model. Id. at 26. See Project, Contempo-
Mental health professionals are also probably better qualified to assess the realities of less restrictive treatment alternatives, such as the administration of drugs on an out-patient basis. Similarly, to the extent that the feasibility of treatment and the probability of success are considered, these areas are arguably the proper subjects of medical experts' opinions when they are familiar with the kinds of treatment available, the quality and availability of treatment facilities, and past successes and failures. Furthermore, even though the limitations of their predictive ability have been recognized, psychiatrists and other mental health professionals are generally considered to be legally qualified as experts to offer their subjective opinions as to the future dangerousness or behavior of a proposed patient.

While these individuals may be legally qualified to opine on the probability of harm and to specify the kinds of situations that will likely involve danger to the proposed patient or others, three issues must still be resolved in a decision to commit. Firstly, given the expert testimony, what is the "validity" of the prediction? Secondly, if accurate, given the testified-to probabilities, can society tolerate this degree of danger? Thirdly, is the harm predicted sufficiently serious enough to outweigh that person's interest in liberty? These questions do not require medical opinions since they represent judgments about the predictions themselves and about the social acceptability of that predicted behavior. Thus, it has been argued that a jury, representing a cross-section of the community, "may be the best agent, not to diagnose mental illness, but to apply the diagnosis of the experts to the social context in

71. It should be pointed out that a psychiatrist or other mental health professional may not have an accurate view of his successes or failures. It has been suggested, for example, in regard to predictions of violent behavior, that the psychiatrist almost never learns about his erroneous predictions of violence since the subjects of those predictions are often detained and have little opportunity to disprove the prediction. On the other hand, his erroneous predictions of non-violent behavior have a high visibility, often in newspaper headlines, which "inclines him, whether consciously or unconsciously, to overpredict rather than underpredict violent behavior." Dershowitz, The Law of Dangerousness: Some Fictions About Predictions, 23 J. LEGAL ED. 24, 46 (1971).


74. Id. at 961.
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which the patient exists." In any event, lawyers, public officials, or others would seem to be as well qualified as medical personnel, if not better, to make these judgments since that is essentially a policymaking and evaluative function.

In sum, mental health commitments involve a convergence of difficult issues relating to legal rights, psychiatric judgments, varying social contexts, and uncertain policy. In light of this convergence, it is suggested that a critical element in achieving as accurate decisions as possible and in maintaining procedural rights is an involvement of a variety of skills and actors. Their involvement, however, should take into account institutional limitations. For example, would it be more sound to find other ways of obtaining community participation in those areas where it seems appropriate other than by use of a jury because of the delays that its use might cause? Would it be more appropriate to utilize a non-judicial setting to avoid association with the traditional criminal process? In addition, the legislative design should attempt to avoid procedures which facilitate pre-emption of the decisionmaking process. For example, would it be wiser to avoid a certification procedure in which an examining physician simply concludes whether or not a person is "mentally ill" or "dangerous" since that procedure may subsume the social policy issues involved in a particular case?

WAIVER AND SUBVERSION OF RIGHTS

Procedural safeguards in actual practice can be subverted by those responsible for administering them. The operation of the pre-1976 commitment system in Nebraska provides several examples of

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75. Id. at 963. Compare Extension of “Criminal” Safeguards, supra note 4, at 266-67 (community input and importance in determining whether burden of proof met; desirability from proposed patient’s point of view when expert testimony is blatantly contradictory or inconclusive), with Weihofen, supra note 21, at 848-52. In Humphrey v. Cady, the Supreme Court noted that involuntary commitment is premised

not solely on the medical judgment that the defendant is mentally ill and treatable, but also on the social and legal judgment that his potential for doing harm, to himself or to others, is great enough to justify such a massive curtailment of liberty. In making this determination, the jury serves the critical function of introducing into the process a lay judgment, reflecting values generally held in the community, concerning the kinds of potential harm that justify the State in confining a person for compulsory treatment.

405 U.S. 504, 509 (1972).

76. Ross points out that the “social case worker, sociologist, or clinical psychologist knows as much about social values as the doctor of medicine, if not more” and suggests that “[i]f impartial experts are to be used, there seems no reason why the panel should be limited to physicians, or even to psychiatrists.” Ross, supra note 73, at 963.
the ways that this subversion can occur. In some instances, pro-
posed patients were not advised of their right to be represented
by private counsel or, if the proposed patient was indigent, to have
appointed counsel and an independent examination at state ex-

depense. In other situations, the person advising the proposed patient
of his right to counsel would encourage waiver of that right. This
encouragement to waive rights was also manifested in more subtle
ways. In one of the counties which used a rights advisory form,
the pattern of questions encouraged waiver. The preliminary ques-
tions on the form required a “yes” answer to each one; the fourth
question was “[d]o you wish to waive your right to an attorney?”

Since both the federal decision and the new Nebraska legislation
permit a waiver of rights, similar subversions of the proposed
patient's rights remain possible.

It should be pointed out that even when the proposed patient
had indicated a preference on a rights advisory form to have
appointed counsel, that request was not always translated into
effective representation for a number of reasons. In one county,
the public defender's office was apparently understaffed and thus
was unable to respond with effective representation. Also that
office may have viewed the defense of “mental cases” as undesir-
able work. Another reason requests were not always translated
into effective representation was the result of delays in forwarding

77. See Administrative Civil Commitment, supra note 7, at 278-79 n.51.

of rights must be scrutinized carefully). Section 83-1064 of the Nebraska
Mental Health Commitment Act provides that rights may be waived only
if the record reflects that the waiver was made “personally, intelligently,
knowingly, understandingly, and voluntarily” by the proposed patient and
his parent or legal guardian if he is a minor or legally incompetent. If
the mental health board determines that the proposed patient is incapable
of waiving his rights under § 83-1064, the proposed patient's counsel shall
in his discretion make the decision. However, when the proposed patient
is not represented by counsel, his rights may not be waived. NEB. REV.

79. In 1974, nineteen percent of the persons processed by the mental
health board in that county requested representation by the public defend-
er's office on the rights advisory form. However, representation by a public
defender could be noted in the board of mental health files in only 0.9 per-
cent of the cases. Administrative Civil Commitment, supra note 7, at 279.
Likewise, interviews with the officials involved in the process and others
indicated that representation by the public defender was often not trans-
lated into effective representation. For example, one practicing attorney
who was familiar with the operation of the commitment process com-
mented:

Their procedure was to give the person a piece of paper which had
on it the opportunity to have an attorney represent them. No one
ever really explained this to anyone and very few people signed.
A number of people who did sign have told me that no one ever
the notice of appointment to the public defender's office. In some rural counties, the attorney appointed was not familiar with mental health law and commitment procedures.\textsuperscript{80}

Adding to these difficulties in some cases was the attorney's own ambivalence about his role in the process. Apparently, some were reluctant to press their clients' legal position if they agreed that the client "needed help." This general ambivalence appears to have been reinforced by a feeling of decreased competency in what was perceived to be a "medical" matter by some attorneys.\textsuperscript{81}

Another way in which a proposed patient's rights may have been subverted was the result of plea bargaining in criminal cases. In some cases counsel apparently viewed civil commitment as involving a lesser "penalty" than that of a criminal offense. Counsel was thus an advocate for commitment and was willing in those situations to encourage waiver of the proposed patient's rights as well as to offer no defense.\textsuperscript{82} While in some of these cases civil commitment may have been justified, in others it may have not

\textsuperscript{80} One former public defender complained about the delay in receiving notice of the appointment. He pointed out that often the office would learn of a case, not from the rights advisory sheet, but from the proposed patient who had prior contact with the public defender's office or from a relative or friend of the proposed patient.

One possible advantage of the public defender system that was pointed out was the opportunity to develop through experience expertise in the representation of proposed patients in commitment proceedings. Several interviewers indicated that in the rural counties the attorneys that were appointed were often young and unfamiliar with commitment procedures.

\textsuperscript{81} It has been pointed out that "many attorneys, aggressive and self-confident in most situations, seem to be insecure and passive in civil commitment matters and abandon their traditional advocacy." Strand, Legal Aid for Patients in State Mental Institutions: The Cleveland Experience, 6 CLEARNINGHOUSE REV. 493, 487 (1972).

\textsuperscript{82} Administrative Civil Commitment, supra note 7, at 280. Cf. Matthews, supra note 10, at 179-83; Note, Commitment of the Mentally Ill in Ohio, 12 W. RES. L. REV. 596, 604 (1961) ("In the past, the Ohio commitment law has been employed by [non-mentally ill persons] who seek admittance to mental institutions in order to avoid criminal prosecution.").
been. It should also be noted that plea bargaining can occur within the commitment process itself, particularly when less restrictive alternatives are available. It seems likely that this type of bargaining will substantially increase under the new Nebraska legislation since it permits suspension of the proceedings for voluntary treatment and requires less restrictive placements.

A proposed patient’s rights could also be subverted under the pre-1976 Nebraska law by an ex parte decision by the committing body to exclude the subject from the proceeding on the ground that his presence would probably be detrimental to him. As discussed earlier, however, an ex parte exclusion is no longer possible under Nebraska law. Another way a proposed patient’s rights could be subverted is by a systematic stretching of commitment criteria to attain therapeutic goals. Although it was not a significant problem under the pre-1976 Nebraska system because Nebraska utilized an extremely broad, treatment-oriented substantive standard, this type of subversion is much more likely to occur under the restrictive substantive standard set forth by the federal court decision and the new Nebraska legislation.


84. See generally text at notes 64-65 supra.


86. See text at notes 40-42 supra. But cf. note 78 supra (waiver of hearing).

87. In their study of Arizona’s system of involuntary commitment, Wexler and Scoville found that a statutory commitment criterion (e.g., dangerousness) may be systematically stretched to attain therapeutic goals. Wexler & Scoville, The Administration of Psychiatric Justice: Theory and Practice in Arizona, 13 Ariz. L. Rev. 1, 101 (1971).


(1) A substantial risk of serious harm to another person or persons within the near future, as manifested by evidence of recent violent acts or threats of violence or by placing others in reasonable fear of such harm; or (2) A substantial risk of serious harm to himself within the near future, as manifested by evidence of recent attempts at, or threats of, suicide or serious bodily harm, or evidence of inability to provide for his basic human needs, including food, clothing, shelter, essential medical care, or personal safety.

PROBLEMS IN THE USE OF ADMINISTRATIVE PROCEDURES AND DECISIONMAKING

Prior to 1976, boards of mental health in Nebraska were composed of a physician, a lawyer, and the clerk of the district court. The Nebraska statutes identified some functions to be performed by particular board members, such as the record-keeping duties of the clerk. Nevertheless, it appears that board members arguably were to be co-equal participants in decisionmaking. It should be pointed out, however, that the pre-1976 Nebraska administrative system experienced problems in the use of multi-member, multi-competency boards. On most of the boards evaluated, the medical member clearly appeared to be the dominant decisionmaker. Role definitions of most non-medical members were limited, ranging from completely passive to limited utilization of particular professional skills. In the latter cases, attorney members tended to view their role as setting procedural boundaries of fairness and as resolving such questions as patient eligibility for county funds. While all non-medical members stated the physician's judgment was not binding on the board, nearly all added that the board almost always accepted his diagnosis and recommendation.

Under prior Nebraska law, the board physician was permitted by statute to be the examining physician and in practice usually was in the counties studied. This possible joint role of the physician was challenged in the suit against the pre-1976 commitment system as a denial of the proposed patient's right to an impartial tribunal. The court found that this procedure combined the investigative, prosecutorial, and adjudicative functions in one authority and therefore was a denial of due process of law. The new legislation remedied this problem by requiring the examination to be conducted by a non-board mental health professional.

Decisionmaking on the boards under the prior system was

90. See Administrative Civil Commitment, supra note 7, at 232.
91. This apparent deference to the physician's recommendations appears to be supported by the statistical data collected from the boards' records. In 1974, disagreement between the physician's certification and the board's finding was noted in only one case out of all cases in which a physician's certification and board finding were made. Id. at 273 n.39.
92. Neb. Rev. Stat. § 83-326 (Reissue 1971) (repealed 1976). In the five counties studied, the board physician was also the examining physician in 93% of the examinations conducted in 1974.
affected by a number of other actual or potential problems. For example, board membership tended to continue indefinitely. Several boards had been composed of the same members for ten to twenty years. While this pattern might bring valuable experience to bear on cases, it also might stifle disagreement and open discussion among board members in the interest of group harmony. Professional training among board members was less than optimal, especially for rural board members. Several board members regarded board membership as a community service, one from which they might prefer to be relieved. This reluctance to serve at all was compounded by a dearth of physicians with psychiatric training outside the largest urban areas. Some of these general problems may be solved by the new Nebraska legislation. Board membership compensation has been increased and the eligibility for board membership has been expanded to include psychologists, psychiatric social workers, psychiatric nurses, and lay persons with a demonstrated interest in mental health issues in lieu of the clerk of the district court.

An important factor which compounded some of the difficulties in decisionmaking was the extremely vague and open-ended statutory design of the pre-1976 law. Among those eligible for commitment as mentally ill were "alcoholics," "sexual sociopaths," "the mentally retarded," "drug abusers," and the "mentally ill," the latter including senile. Along with these highly inclusive parameters, the statutes provided virtually no guidance as to who fit these categories, and as to who, among those in the categories, were "ill" enough to warrant commitment.

It has been demonstrated in several studies that vagueness in statutory design of administrative systems leads to several prob-

95. A number of studies of organizations have found that social systems within the organization moderated internal conflict and encouraged group harmony. See, e.g., D. Neubauer, Criminal Justice in Middle America (1974) [hereinafter cited as Neubauer]; D. Matthews, U.S. Senators and Their World (1960); J. Wahlke, The Legislative System (1962).

96. Retired or semi-retired general practitioners were often members of the rural boards. One possible exception to the statement that board membership rarely contributed to private practice was noted in the case of one medical board member with an extensive psychiatric practice.


98. Under the new legislation, it is possible that a physician need not be appointed to the board at all since any two from the list in the text may be appointed in lieu of a physician, provided that not more than one from any class is chosen. Neb. Rev. Stat. § 83-1018 (Cum. Supp. 1976).

Lacking external rules and standards, individual decision makers must develop their own. Initially, one response may be *ad hoc*, case by case decisions from which only erratic and unstable general rules can be discerned. Eventually, these rules usually evolve into a more stable pattern where decisionmakers have developed some general framework. Case by case, *ad hoc* administration removes predictability from administration. Not only did the standards differ from one board to another, they varied non-rationally within a single board.

The general rules evolving over a period of time from a number of cases under vague statutory standards are likely to be unsatisfactory for several reasons: Differences among the boards continue; general coordination and supervision to assure equity and efficiency are difficult; and the rules evolved usually emerge because these best cope with immediate pressures and demands. Such factors as case load, types of cases, available facilities, and pressure from other institutions and actors tend to determine operating policy. Such policy thus may or may not satisfy public health needs or embody rights and decisionmaking required by procedural due process.

In one Nebraska board, for example, clerical and board personnel utilized informal and unofficial discouragement of potential initiators of actions to reduce the number of cases filed. Another board responded to public abuses regarding intra-family disputes by refusing to accept informations filed by parties involved in divorce actions. In another situation, a board with an unusually high case load which was characterized by large numbers of indigent alcoholics responded by processing virtually every proposed patient into a mental hospital for two or three days, so that hospital personnel had a significant, if not determinative, role in


102. Cf. R. Linberry & I. Sharkansky, *Urban Politics and Public Policy* (1971); Lipsky, note 101 supra; Lipsky & Olsen, note 100 supra; Nadel, note 101 supra; Neubauer, note 95 supra; Selznick, note 101 supra (decisionmaking factors used in other urban problem areas).
final board decisions. While this procedure may have been an efficient, non-discriminatory means of handling civil commitment, it neutralized nearly all formal procedural safeguards and altered a multi-competency, multi-actor administrative process into a "medical" procedure.

In short, the Nebraska legislature in its pre-1976 commitment laws did not establish guidelines defining the potential subjects for commitment nor did it establish clear standards of illness within any category. Boards and local populations had difficulty establishing their own guidelines as to eligible cases. As a result, boards may have, at times, been overly restrictive and at times under-restrictive in accepting cases, and widely varying systems emerged.

The revision of commitment standards and procedures by the new Nebraska legislation should alleviate many of these problems experienced by Nebraska's boards of mental health. Other changes in legislative design directed to these problems are presented in the following section.

LEGISLATIVE DESIGN

The legislative drafting and statutory design of any administrative system are difficult, and the design of a civil commitment system is perhaps more difficult than most. Constitutional prescriptions demand that attention be paid to a complex and often murky balancing process. Mental illness is difficult to diagnose and to relate to future behavior. If currently operating systems are too severely disrupted, social pressures to maintain order in this field might be expected to increase. Administration within such uncertainty and potential pressure is particularly difficult, especially within current economic and political realities.

At the most general level, civil commitment systems might be expected to fulfill two requirements: Commitments and dispositions must be made which are appropriate to patient conditions and needs; and the commitment process must observe essential substantive and procedural due process requirements. It is important to note that these two characteristics do not necessarily accompany one another. In the Nebraska system, a number of specific problems have impeded successful achievement of these goals. The following elements in the legislative design of commitment systems—judicial or administrative—are suggested as appropriate modifications of many current statutory schemes. Some of these general suggestions have been incorporated into the new Nebraska commitment law:
(1) specific commitment criteria, stated in reasonably precise terms, should be developed to guide decisionmakers in the administration of any commitment scheme;
(2) the number and variety of disorders eligible for commitment should be limited by the legislature;
(3) clear evidentiary findings should be required as a necessary precondition for involuntary commitment;
(4) genuine participation in evaluation and disposition of cases by all statutory committing authority members must be ensured so as to avoid "expert" dominance of the decision-making process;
(5) general limitations on resources, including financial and professional, must be considered and statutorily adjusted to in order to avoid detrimental local, extra-legal adjustments;
(6) varying local conditions, including population size, epidemiological patterns, available resources, and committing authority under- and overloads, must be considered and adjusted to;
(7) extensive, impartial, and accurate examinations and diagnoses must be assured and related to commitment criteria;
(8) a variety of dispositional alternatives should be available to committing authorities and a requirement of the use of less restrictive alternatives should be specified; and,
(9) specific problems in assuring procedural due process must be remedied by specific legislative provisions.

A brief discussion and development of each of these suggested elements in legislative design follows.

Specific Commitment Criteria

Current commitment statutes generally require as a fundamental element of their substantive commitment standard that the proposed patient be "mentally disabled" and suffering from one or more of the following incapacitating conditions: having impaired judgment; needing hospitalization; needing care or treatment; or being dangerous to self or others. However, many states fail to specify adequately the class affected and the degree of incapacitation in adequate detail to establish sufficiently clear guidelines for decisionmakers. The effect of many ill-defined substantive commit-

103. Brooks, supra note 69, at 675-76.
ment provisions is to enhance medical dominance of decisionmaking by subsuming social value judgments and to require the committing authorities to develop their own guidelines.

The difficulties of administering a commitment scheme using open-ended substantive criteria are typified by the Nebraska system prior to 1976. As discussed previously, the boards developed over a period of time a variety of general rules and informal procedures which at times did not satisfy public health needs, nor did those rules and informal procedures embody rights and decisionmaking envisioned by the statutory scheme. In other states as well, it has been shown that a general criterion may allow for subversion of the legislative standards.104

It is thus suggested as a matter of sound policy and compliance with substantive constitutional mandates that specific commitment criteria should be developed by the legislature. One means of providing specific standards is a legislative enumeration of the requisite elements of a statutory term. For example, the components of “dangerousness” could be stated, including the magnitude of harm, its probability of occurring, its frequency, and its imminence.105 Another means of providing sufficient guidelines would be a negative statutory statement. For example, the statute might state that a finding that a person would be benefited by some treatment shall not be a sufficient ground for involuntary commitment. Likewise, the commitment statute may be prefaced with a detailed legislative statement of public policy to guide decisionmakers and courts in interpreting the statute.

LIMITATION OF NUMBER AND VARIETY OF DISORDERS

In regard to the scope of the substantive provisions themselves, it is suggested that a number and variety of disorders eligible for commitment should be limited. Such a strategy would presumably allocate the state's scarce resources to those identified by the state as most requiring or benefiting from them. It would also serve to reduce frivolous and inappropriate filings,106 ease overloads, and aid in administration by reducing the number of categories for

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104. See, e.g., note 87 supra.
105. See Brooks, supra note 69, at 680-82.
106. The potential of involuntary commitment to be used as a coercive or punitive device is a danger of which all board members were aware. Such an abuse is especially dangerous in intra-family filings. On the other hand, family members might be expected to be among those most sensitive to altered behavior and imminent mental crisis. In handling this two-sided problem, boards under the pre-1976 system were hampered by their limita-
which the committing authorities must develop measurement systems. In general, means of voluntary commitment should be made readily available and encouraged in lieu of involuntary commitment to reduce case load pressures on the formal commitment mechanism.

**Evidentiary Findings**

Many commitment statutes do not specify evidentiary guidelines to help reduce improper or arbitrary decisionmaking. In the case of dangerousness, for example, the statutes should require clear proof of past acts of violence, recent overt attempts or threats, or past conduct.\(^{107}\) Proof beyond a reasonable doubt of factual allegations on which the commitment is based should be statutorily required and, at a minimum, clear and convincing evidence of mental illness or dangerousness should be legislatively required.

**Committing Authority Membership Participation**

Two strategies might be employed to assure multi-member, multi-competency participation in hearings. The first strategy attempts to avoid pre-emption by one member by emphasizing authority unity and reducing members’ opportunities to pre-empt decisions. This strategy would require the statutes to specify clearly the joint nature of the authority’s decision, emphasizing the shared responsibility and authority of the entire body. The shared responsibility should be stated affirmatively and linked to statutory specification of each conceptually distinct step of the commitment process. All tasks explicitly related to the medical member's area of competence should be removed to external medical examiners. This procedure would help prevent a single member from pre-empting decisionmaking via a monopolization of a critical decision point.

\(^{107}\) See note 88 supra; cf. Minnesota ex rel. Pearson v. Probate Court, 309 U.S. 270, 274 (1940). Wexler and Scoville view Pearson at a minimum as suggesting that “specific conduct is a constitutionally preferable test of future dangerousness, and may well be the only constitutionally adequate standard.” Wexler & Scoville, supra note 87, at 100.
A second, rather different strategy would attempt to ensure multi-member, multi-competency participation by compartmentalizing decisionmaking among the various actors. Statutes defining decisionmaking authority and responsibility would explicitly allocate roles according to participants' specialized abilities, thereby avoiding deference to other actors. It appears that when specific decisionmaking authority is not explicitly set forth in the commitment statutes, participants may defer to others in the process who may be less qualified to make the relevant decisions. For example, if a judge perceives the issue to be a medical one and the commitment statute requires a conclusionary finding to be made by the medical examiner or emphasizes "mental illness" or "disease," a judge may completely defer to the medical expert's judgment as to the appropriateness of hospitalization. Psychiatric labeling of the proposed patient probably reinforces this deference to a substantial degree. Thus, even though the legislature may place responsibility on a judge or a commission with non-medical personnel, the real authority may in fact lie with the medical examiner if the legislature does not take steps to allocate authority explicitly. To aid in allocating this authority and in clarifying the issues involved in involuntary commitment, the statutes should require special verdicts if a jury is used, explication of the facts and circumstances on which medical experts base their opinions, and specific consideration of the probability of certain behavior occurring and the harm or the degree of danger society can tolerate. Generalized questions such as, is this proposed patient a "proper subject for commitment?" or is he "dangerous?" should be avoided.

Each strategy is vulnerable to some problems. The first approach would fail if individuals still chose to take a passive role. In such a case, members perceived as most competent or members who are most assertive would probably control supposedly "joint" decisions. The second strategy is vulnerable to fragmentation of decisionmaking responsibility, control of critical decision points probably by medical members, and loss of the advantages of a multi-member, multi-competency strategy if decisions become overly segmented. This second strategy may be best suited to judicial commitment systems, where segmental decisionmaking is more familiar to regular participants.

General Resource Levels

Strategies requiring generally unrealistic allocations of resources to civil commitment are unlikely to solve the genuine problems such systems have experienced. Such reformist strategies,
in demanding the impossible, are likely to cause system breakdown or development of another informal system vulnerable to all the failings of the old.108

Requiring a psychiatrist, for example, to sit on every authority or to perform every medical exam is doomed to fail in rural or small population areas. Authorities then would be likely either to evade statutory requirements or to cease functioning. Converting administrative commitment to judicial commitment in urban areas with already heavy court dockets might encourage a subsystem in the mental health area similar to criminal plea bargaining. Requiring repeated hearings on each case would add to the overload when lack of time is already a source of problems and would probably make it more difficult for committing authorities to recruit and retain members.

It should be noted that one of the strengths of the Nebraska civil commitment system prior to the three-judge federal court decision was its correspondence with available resources. While in some situations greater resources might have been available to the boards and could have been usefully employed, few of its dysfunctions could be attributed to unrealistic resource requirements.

VARYING LOCAL CONDITIONS

Related to, but broader than, the issue of resources are the widely varying local conditions which characterize most states. In Nebraska, for example, one five-county area included a highly urbanized county with two university teaching hospitals, a state mental health facility, a large number of psychiatric medical specialists, and an immense caseload. The surrounding area included a largely “bedroom” county, one county with a medium (25,000) size city, and two largely rural counties. One of the latter counties had a case load of seventeen applications, about two percent of the case load of the largest county. Yet the identical

108. Reformers must become and remain aware that law is supported, nullified, and sometimes subverted by its more general socio-economic environment. Enacting a law or expounding a judicial pronouncement may create a legal fact, but not necessarily a social reality. The possibilities of intensified social conflict, public alienation from seemingly non-democratic institutions, inadequate funding, disruption of existing systems and institutions, vulnerability to private interest subversion, and administrative infeasibility must be weighed along with the relevant legal and constitutional issues if policymaking is to be more than, at best, irrelevant, and, at worst, counter-productive. See, e.g., Lowi, note 100 supra; L. Harris, The Anguish of Change (1973); S. David & P. Peterson, Urban Politics and Public Policy: The City in Crisis (1973).
administrative structure was established in each county.

In such situations it seems apparent that identical structures cannot, in any real sense, provide equality or even efficiency. Under a single body of law which establishes the commitment guidelines, varying administrative structures could be constructed to fit varying localities.

Possibly a two or three “tier” system might be most effective. Metropolitan areas might set up full-time, salaried authorities and take advantage of available psychiatric skills for all external examinations. Rural areas might maintain part-time authorities, and turn to regional centers with psychiatric facilities in unclear or disputed cases. Small and medium size towns and cities might develop a middle level alternative to professionalized full-time metropolitan authorities, and to rural part-time authorities. Alternative arrangements could be assigned according to case load, population, available resources, or an index based on all three factors.109

EXAMINATION AND DIAGNOSIS

In any system of involuntary commitment, examination and diagnosis are the heart of the process. Regardless of other changes, a system can be no better than the quality of examinations and diagnoses. Some changes which have already been discussed relate this aspect of commitment. A number of additional changes might be considered:

The initiation of an involuntary commitment should be limited to specific groups of persons. In many states any person can initiate a commitment action. It would seem, however, to be a better legislative design to limit the class of individuals who could actually begin the process. Those persons might include the county attorney or some other public official, a physician, a guardian of the proposed patient, or an immediate relative. In some of the counties in Nebraska the board itself refused to accept applications in cases where it felt that the case was not meritorious. Sometimes the secretary to the board or clerk of the court accomplished the same purpose. On the other hand, in some of the counties the clerk of the court accepted the application of any citizen without question and issued a warrant of arrest for the proposed patient. In essence, there should be a screening function recognized in the statute to eliminate obviously inappropriate cases for involuntary commit-

109. Such a system might not be unlike the multi-charter arrangements used by many states to provide urban areas with flexible municipal political institutions. See generally E. BANFIELD & J. WILSON, CITY POLITICS (1963).
Under the new Nebraska legislation, the county attorney performs this screening function. To the extent that resources permit, independent examinations by at least two qualified examiners should be encouraged. It is suggested that the quality of the decisionmaking process may be improved by having more and different inputs into that process, particularly in light of the deference often shown to the medical experts' recommendations. More than one independent examination would increase the number of opinions which the committing authority could take into account in making its decision. Furthermore, independent examinations may lead on occasion to conflicting recommendations and thus may stimulate more complete discussion and participation by all decisionmakers.

The committing authority should be authorized by statute to order a factual investigation by a social worker or peace officer. This investigative function should be recognized since it may provide the committing authority valuable information. In Nebraska, such a function was placed on the examining physician under prior law, but it would seem better to allow these additional inputs since the physician may be ill-equipped to carry out this type of investigation. Under the new Nebraska law, this function will now apparently be carried out through the county attorney's office.

The statutes should emphasize that the medical experts' examinations and reports should include specific facts and not merely conclusions. The statutes should require that the expert's report state the facts and circumstances on which his opinion is based. The report should include the probabilities that certain dangerous behavior will occur, the kinds of situations which involve danger to the proposed patient or others, what the probability of a successful cure is, and how long it will probably take. The emphasis should be placed on a factual description of the proposed patient's present

112. See Administrative Civil Commitment, supra note 7, at 282.
113. Neb. Rev. Stat. § 83-328 (Reissue 1971) (repealed 1976). "In connection with his examination the physician shall endeavor to obtain from relatives of the person in question, or from others who know the facts, correct answers so far as may be to the interrogatories required by this act." Id.
condition and not on conclusions whether he is "mentally ill," "psychotic," etc.\textsuperscript{115}

**DISPOSITIONAL FLEXIBILITY AND LESS RESTRICTIVE ALTERNATIVES**

Some commitment statutes establish decisionmaking authority and criteria which are essentially binary ("yes/no") in nature. For example, the Nebraska statutory scheme provided for commitment to a state mental hospital if it were decided a person was mentally ill. The statutes did not make any reference to degrees of mental illness nor did they grant authority to the local boards of mental health to make less drastic placements, such as out-patient treatment, commitment to local social agencies, or probation.\textsuperscript{116} Such a binary system, it is suggested, often discourages more rational and less restrictive placements. Thus, a variety of dispositional alternatives should clearly be made available to committing authorities.

Coupled with this range of dispositional alternatives should be a statutory requirement of the use of placements which have a smaller adverse impact on constitutionally protected values when feasible.\textsuperscript{117} The utility of this requirement may depend in part on the state's willingness to provide the committing authority resources to investigate the possible alternative placements. However, a less restrictive alternative requirement, if carried to an extreme,\textsuperscript{118} may require action beyond the decisionmakers' competence to investigate properly the social and economic issues.


\textsuperscript{116} Administrative Civil Commitment, supra note 7, at 281.


\textsuperscript{118} For example, the court in Lessard v. Schmidt, required:

\[T\]he person recommending full-time involuntary hospitalization must bear the burden of proving (1) what alternatives are available; (2) what alternatives were investigated; and (3) why the investigated alternatives were not deemed suitable. These alternatives include voluntary or court-ordered out-patient treatment, day treatment in a hospital, night treatment in a hospital, placement in the custody of a friend or relative, placement in a nursing home, referral to a community health clinic, and home health aid services. 349 F. Supp. 1078, 1096 (E.D. Wis. 1972), vacated and remanded on other grounds, 414 U.S. 473 (1974).
involved in assessing the alternatives and may create problems in administration because of statutory vagueness. One means of increasing dispositional flexibility but maintaining committing authority integrity in making less restrictive placements might be to have a state-wide body annually review and revise a list of dispositional alternatives, from which particular local committing authorities could choose. Dispositional placements might thus be tailored to the available local alternatives to full-time hospitalization in a state facility. These alternatives may be out-patient treatment, placement in an approved nursing home, referral to a local community health clinic, or other appropriate dispositions which reflect available resources and the investigative ability and nature of the committing authority.

PROCEDURAL RIGHTS

Some changes in regard to legislative design of procedural safeguards include:

The statutes should require that the notice of the proceedings include a simplified explanation of the commitment process and the proposed patient’s rights. Such a statement would seem to be an essential element in the fairness of the procedures and may have the added effect of facilitating the person’s understanding of the process. If a mental health professional is available to serve the notice, that option should be given statutory preference. The duties of counsel should be affirmatively stated in the statute. Often when private or appointed counsel represents a person before a committing authority, he may be unfamiliar with the process and his duties. One place to which counsel would naturally look in such a situation is to the statutes controlling the commitment process. The enumeration of duties should include an affirmative duty of the attorney to communicate with the pro-

120. Such a body could be composed of specialists in psychiatric treatment, mental health law, and public administration.
121. The competence of the committing authority in making less restrictive placements depends in part on its composition, e.g., whether it consists solely of judicial personnel or whether it is an administrative body that includes medical personnel or mental health specialists.
122. See text at notes 30-31 supra.
123. See note 80 supra.
posed patient, to prepare prior to the hearing, to explain the proposed patient his rights and the process generally, and to press his client’s case to the fullest.

The statutes should emphasize that the waiver of rights by proposed patients should be carefully scrutinized. They should not allow waiver by medical personnel to protect the individual from the “traumatic effects” of notice or his presence at hearings. From a legal point of view, waiver of rights by a proposed patient can be made only when it is done intelligently, knowingly, and voluntarily. Since a person’s mental condition is a key issue in the proceeding, waiver of rights, particularly legal counsel in cases of doubt, should be rejected. Some of the rural boards followed this practice as a matter of course even though such a requirement was not stated in the Nebraska statutes. Likewise, the statutes should not permit waiver of other rights by the committing authority or medical personnel, such as excluding the proposed patient from hearings on the grounds that it would be detrimental to him.

The statutory scheme should specifically prohibit conflicts of interest. Some statutes recognize that a physician may have a conflict of interest and prohibit commitment on the basis of a financially interested physician’s report. The prohibition of conflicts of interest should be extended to cover any member of the committing authority and attorneys in commitment cases. The “prosecutor” of cases before the committing authority should also not be that authority’s legal advisor. Nor should a public defender who initiates a commitment proceeding as a result of a plea bargain act as counsel for the proposed patient in the commitment proceeding. In these situations the statutory scheme should provide for a means of substitution for the person who has a possible conflict of interest.

A state-wide independent authority, agency, or mental health officer should be empowered statutorily to investigate the operation of the mental health system and to intervene in commitment proceedings. A number of states have experimented with this concept. It might be useful in helping rural boards or other

within which duties must be performed by counsel). See also Brunetti, The Right to Counsel, Waiver Thereof, and Effective Assistance of Counsel in Civil Commitment Proceedings, 29 Sw. L.J. 684, 713 (1975).

125. See generally Brunetti, supra note 124, at 699-706; Developments, supra note 3, at 1313-16; note 78 supra.

126. Administrative Civil Commitment, supra note 7, at 279.

127. See, e.g., N.Y. MENTAL HYG. LAW § 70 (1971).

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committing authorities establish their working rules and procedures and in helping avoid informal procedures which reduce patient rights or nullify clear legislative intent. It could operate to ensure general comparability in decisionmaking criteria and, possibly, as a mental health "ombudsman" for those committed.  

CONCLUSION

In a variety of situations, the Nebraska experience suggests that failure to provide procedural rights in a meaningful way can occur as a result of pressure of case load, incompetency of officials, ignorance of law, attitudes toward mental illness which lead officials to believe that statutory protections are inappropriate or unnecessary, pressure from other professionals, time limitations, or other reasons. Likewise, even when there has been an apparent formal provision of required procedural rights, there still may be non-substantive compliance, such as routine approval at later "independent" decision points of prior decisions or cursory hearings and examinations by officials.

Perhaps the conclusion at which one arrives is that workable and sensitive commitment systems require more than legislative mandates and well meaning role occupants. Specifically, throughout the previous commitment system no board participant had a casual or arbitrary view of the nature of the system or of the nature of his role within it. Either in immediate human or more general constitutional terms they appeared to be aware of the import of their actions. Several board members, in fact, expressed concern and dissatisfaction regarding board performance. However, ambiguities and uncertainties inherent in mental health diagnosis, faulty legislative design, or general environmental factors apparently overwhelmed their good faith and their ability to develop internal reform.

This article has suggested several changes in statutory design of commitment systems to correct some of these problems and to make procedural rights more effective in actual practice. Although the proposed modifications have been derived from study of an administrative system of civil commitment, many of them are also

applicable to problems encountered in the administration of judicial commitment systems. It is suggested that careful legislative design of commitment procedures, proper allocations of decisionmaking authority, and effective provision of due process safeguards can do much to relieve the current criticism of the mental health commitment process and to improve the decisionmaking in commitment cases.