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The Failure of the Federal Courts to Incorporate O'Connor's Dangerousness Requirement into the Standards Utilized in Actions Challenging Wrongful Civil Comments

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THE FAILURE OF THE FEDERAL COURTS TO INCORPORATE O'CONNOR'S DANGEROUSNESS REQUIREMENT INTO THE STANDARDS UTILIZED IN ACTIONS CHALLENGING WRONGFUL CIVIL COMMITMENTS

Svetlana Walker[*]

I. INTRODUCTION

Civil commitment is defined as "[a] commitment of a person who is ill, incompetent, drug-addicted, or the like, as contrasted with a criminal sentence."[1] The definition attempts to capture the main distinction between the two types of confinements: it points out that at the basis of civil commitment lays one's status, while at the basis of criminal sentence lays one's action. The question then becomes whether the status alone is enough to civilly confine an individual. Although the Supreme Court already answered this question in the negative,[2] the practical reality is not in sync with the law. It becomes noteworthy then that sometimes dictionaries capture not only the meaning of the term, but also the practical reality behind it.

Mentally ill individuals have been secluded from the rest of

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[1] BLACK'S LAW DICTIONARY 116-17 (4th pocket ed. 2011).

[2] *See* O'Connor v. Donaldson, 422 U.S. 563, 576 (1975) (providing that "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends").

the society for centuries.[3] At first they were placed in jails and shelters for the poor, then in asylums for the lunatics, and later into psychiatric institutions.[4] Prior to the Supreme Court's landmark decision in *O'Connor v. Donaldson*,[5] the "need for treatment" standard governed all civil commitments.[6] Under this standard, the presence of mental illness and a doctor's recommendation for continuous treatment were sufficient to institutionalize an individual for an indefinite term.[7] Courts and states paid little attention, if any, to the commitment process during this time.[8] The era of the "need for treatment" requirement signified the utmost decision-making power ever vested in psychiatrists.[9] Unsurprisingly, when there is no check on this power, abuse can follow.[10] To correct this injustice, in 1975, the Supreme Court announced that only a successful satisfaction of a new dual requirement of mental illness and dangerousness could produce a civil commitment.[11] It was no longer enough to have only a doc-

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[3] *See* Megan Testa & Sara West, *Civil Commitment in the United States*, 7(10) PSYCHIATRY 30, 31-32 (2010).

[4] *Id.* at 32.

[5] 422 U.S. 563 (1975).

[6] *See, e.g.*, William M. Brooks, *The Tail Still Wags the Dog: The Pervasive and Inappropriate Influence by the Psychiatric Profession on the Civil Commitment Process*, 86 N.D. L. REV. 259, 314 (2010) (explaining that "[p]rior to O'Connor v. Donaldson and its progeny, both the law and clinical practice required psychiatrists to assess only mental illness and a need for treatment").

[7] *Id.* at 261.

[8] *See* Paul S. Appelbaum, *A History of Civil Commitment and Related Reforms in the United States: Lessons for Today*, 25 DEV. MENTAL HEALTH L. 13, 14 (2006) (explaining that "what existed during this time was an informal system that evolved without statutory authority, criteria, or procedures, and that placed commitment decisions entirely in the hands of . . . the medical profession, without any role for the state or the courts").

[9] *Id.*

[10] *See, e.g.*, Testa, *supra* note 3, at 32 (describing the first documented challenge to a questionable involuntary confinement that was brought by Mrs. Mary Packard. She was committed to a psychiatric facility in Illinois in 1860, pursuant to her husband's request. Mr. Packard was convinced that his wife was possessed by a bad spirit. His conviction stemmed from the fact that Mrs. Packard was attempting to explore religious beliefs other than Presbyterian. As a result, Mrs. Packard was diagnosed with "moral insanity" and spent three years in the institution. Upon release, Mary Packard learned that she lost all her parental and property rights.); *see also* John Kip Cornwell, *Understanding the Role of the Police and Parens Patriae Powers in Involuntary Civil Commitment Before and After Hendricks*, 4 PSYCHOL. PUB. POL'Y & L. 377, 379-80 (1998) (describing the case of one Hinchman who claimed that his "relatives had conspired to commit him to an asylum for the purpose of depriving him of his property"). The court in *Hinchman* affirmed "the common law right of family and friends to restrain the non-dangerous insane for their own benefit." *Id.* at 380.

[11] *O'Connor*, 422 U.S. at 575 (providing that "there is . . . no constitutional basis for confining [mentally ill] . . . if they are dangerous to no one and can live safely in freedom").

tor's recommendation to confine an individual.[12] From now on, the status of mentally ill had to be accompanied by dangerousness to either self or others.[13] More importantly, it became the judges' role to examine psychiatrists' findings to determine whether or not someone is to be committed.[14]

Millions of people have been institutionalized since *O'Connor*.[15] Undoubtedly, many commitments were justified; however, some were wrongful. Those patients who challenged their confinements, seeking the imposition of liability for their wrongful civil commitments on committing mental health professionals acting on behalf of the State, faced very pro-commitment legal standards that were almost impossible to satisfy.[16]

Currently, to decide whether liability for wrongful civil commitment should be imposed on psychiatrists acting on behalf of the state, courts look at anything but the *O'Connor* requirements.[17]

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[12] *See, e.g.*, Doremus v. Farrel, 407 F. Supp. 509, 514 (D. Neb. 1975) (acknowledging that "[t]o 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").

[13] *O'Connor*, 422 U.S. at 576.

[14] *See* Brooks, *supra* note 6, at 262-63 (explaining that after *O'Connor*, courts became "the decision-makers as to whether patients have satisfied the civil commitment criteria").

[15] *Id.* at 261 (stating that "[i]n the United States, psychiatric hospitals involuntarily confine more than one million individuals per year").

[16] *See* Rosalie Berger Levinson, *Wherefore Art Thou Romeo: Revitalizing Youngberg's Protection of Liberty for the Civilly Committed*, 54 B.C. L. REV. 535, 558-59 (2013):

> Despite its drawbacks, however, the . . . [gross negligence] standard has become the best shield for plaintiffs against arbitrary government decision making. An examination of *Lewis* and its progeny demonstrates that the Supreme Court's adoption of the shocks-the-conscience standard for substantive due process violations has imposed a nearly insurmountable obstacle to holding government officials responsible for their abuses of power.

Id. See also Susan Stefan, *Leaving Civil Rights to the "Experts": From Deference to Abdication under the Professional Judgment Standard*, 102 YALE L.J. 639, 646 (1992).

[17] *Compare* Rodriguez v. City of New York, 72 F.3d 1051, 1063 (2d Cir. 1995) (deciding the issue of imposition of liability on state psychiatrists by reviewing whether the committing mental health professional's decision to confine was made on the basis that is "substantially below the standards generally accepted in the medical community"), *and* Bolmer v. Oliveira, 594 F.3d 134, 143 (2d Cir. 2010) (same); Jensen v. Lane Cnty., 312 F.3d 1145, 1147 (9th Cir. 2002) (same); *with* Benn v. Universal Health Sys., Inc., 371 F.3d 165, 174 (3d Cir. 2004) (imposing liability on state psychiatrists only if their decision to commit an individual, under the circumstances, shocks-the-conscience); Obado v. UMDNJ, Behavioral Health Ctr., 524 F. App'x 812, 815 (3d Cir. 2013) (same); *and* James v. Grand Lake Mental Health Ctr., Inc., No. 97-5157, 1998 WL 664315, at *1, *7 (10th Cir. Sept. 24, 1998) (same).

Some federal courts inquire whether the committing mental health professional's decision to confine was "substantially below the standards generally accepted in the medical community;"[18] others ask whether the decision to commit shocked the conscience.[19] There is not a single federal court that would investigate whether the constitutional bases, announced by the Supreme Court in *O'Connor*, were satisfied.

A simple syllogism can lend a hand in clarifying an important point. When an individual challenges his or her wrongful commitment, he or she alleges that the legal grounds for such commitment were not present; the individual was either not mentally ill, not dangerous, or both. It is logical then that when an individual challenges his or her confinement and seeks damages, the courts should inquire whether the person was both mentally ill and dangerous. Leaving aside the issue of qualified immunity, if one of the requirements is absent, the committing psychiatrist should be liable. However, under the present standards, federal courts examine the state actors' conduct without paying any regard to the constitutional requirement of dangerousness announced in *O'Connor*.[20] The failure of the federal courts to incorporate the *O'Connor* dangerousness requirement into their existing legal standards leads to numerous intolerable deprivations of liberty without any repercussion.

In 2010, the National Council on Disability, in its report to President Obama, stated that "[p]eople with psychiatric disabilities are routinely deprived of their rights in a way no other disability group has been."[21] This statement is the best testament demonstrating that American jurisprudence has yet to afford the mentally ill the level of protections that due process of law requires. These protections should not be any less stringent only because the word "civil" precedes the word "commitment" and because the population affected is comprised of individuals touched by mental disease.

This Comment will provide a historic overview of the development of the presently existing legal standards utilized in challenges

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[18] *See Rodriguez*, 72 F.3d at 1063; *Bolmer*, 594 F.3d at 143; *Jensen*, 312 F.3d at 1147.

[19] *See Benn*, 371 F.3d at 174; *Obado*, 524 F. App'x at 815; *James*, 1998 WL 664315, at *7.

[20] *See Benn*, 371 F.3d 165; *Bolmer*, 594 F.3d 134; *Jensen*, 312 F.3d 1145; *Rodriguez*, 72 F.3d 1051; *Obado*, 524 F. App'x 812; *James*, 1998 WL 664315, at *1.

[21] *From Privileges to Rights: People Labeled with Psychiatric Disabilities Speak for Themselves*, NATIONAL COUNCIL ON DISABILITY (Jan. 20, 2000), *available at* http://www.ncd.gov/publications/2000/Jan202000.

to wrongful civil commitments and will suggest the need to incorporate the *O'Connor* requirements into them to afford truly meaningful constitutional protections for individuals with mental illness. Section II will discuss the current constitutional requirements that govern civil commitments. It will also discuss several reasons why, in practice, the *O'Connor* requirements routinely are overlooked. Further, it will instruct courts and states on what they can do to solve this problem. Section III will explore the development of federal case law in jurisdictions that are split on the issue of what legal standard governs the imposition of liability on state psychiatrists. Finally, it will emphasize the need for the incorporation of the *O'Connor* requirements in presently existing legal standards.

II. THE COMMITMENT REQUIREMENTS OF *O'CONNOR V. DONALDSON*

Prior to 1975, the only standard that governed civil commitments was the "need for treatment."[22] Under this standard, the only requirements that needed to be satisfied were the presence of mental illness and a doctor's certification that a patient would benefit from treatment.[23] During this era, courts and states were not heavily involved in the initial commitment process.[24] All the power to commit rested in the sole hands of psychiatrists.[25] Undoubtedly, this power was at times abused.[26] Civil rights movement pioneers and advocates for the mentally ill ultimately brought to light numerous incidents of injustice.[27] The Supreme Court responded and attempted to impose a

[22] *See* Cornwell, *supra* note 10, at 381-82 (noting that The National Institute of Mental Health's Draft Act Governing the Hospitalization of the Mentally Ill "advocated the commitment, on a need-for-treatment basis, of individuals who had 'a psychiatric or other disease which substantially impairs . . . mental health' ") (quoting NAT'L INST. OF MENTAL HEALTH, DRAFT ACT GOVERNING THE HOSPITALIZATION OF THE MENTALLY ILL (1952)).

[23] *Id.* at 383 (explaining that "[t]he Mental Health Act conditioned detention on a finding that an individual was 'mentally ill' and 'a proper subject for custody and treatment,' defining mental illness as 'mental disease to such extent that a person so afflicted requires care and treatment for his own welfare, or the welfare of others, or of the community' ") (quoting Humphrey v. Cady, 405 U.S. 504, 509 n.4 (1972)).

[24] *See* Appelbaum, *supra* note 8 and accompanying text.

[25] *See* Brooks, *supra* note 6, at 262 (providing that "great discretion in the hands of physicians: whether a person requires care and treatment for mental illness requires a clinician to simply exercise clinical judgment as a way to determine whether a patient satisfies the legal criteria for civil commitment").

[26] *See supra* note 10 and accompanying text.

[27] *See* Cornwell, *supra* note 10, at 380 (stating that "sharp increases in the number of psy-

check on physicians' prior unrestricted power.[28]

In *Addington v. Texas*,[29] the Supreme Court proclaimed that "civil commitment for any purpose constitutes a significant deprivation of liberty that requires due process protection."[30] In *O'Connor*, the Supreme Court established such constitutional protections and provided that only a simultaneous showing of both mental illness and dangerousness, either to one's self or to others, can justify one's liberty deprivation.[31] This remains the governing standard to this day.

In *O'Connor*, Kenneth Donaldson, a psychiatric patient of fifteen years, brought an action challenging his confinement.[32] He argued that the state hospital staff had "intentionally and maliciously deprived him of his constitutional right to liberty."[33] Although he was clinically diagnosed with paranoid schizophrenia,[34] he showed no signs of being dangerous, neither to himself nor to anyone else throughout the entire duration of his commitment.[35] The Supreme Court declared that "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in the freedom by himself or with the help of willing and responsible family members or friends."[36]

The practical effect of the newly announced standard was profound. In replacing the old "need for treatment" standard with the new, seemingly objective criteria, the Court transferred the ultimate decision-making power from psychiatrists to judges.[37] Going forward, it was no longer sufficient for a psychiatrist to merely certify

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chiatric hospitals, combined with public concern about erroneous commitment and the personal rights of the insane, led to the enactment of statutes in various states specifying substantive standards for commitment").

[28] *See O'Connor*, 422 U.S. at 563.

[29] 441 U.S. 418 (1979).

[30] *Id.* at 425.

[31] *O'Connor*, 422 U.S. at 575.

[32] *Id.* at 564-65.

[33] *Id.* at 565.

[34] *Id.* at 565-66.

[35] *Id.* at 568.

[36] *O'Connor*, 422 U.S. at 576.

[37] *See* Brooks, *supra* note 6, at 262-63:

> In theory, the imposition of a dangerousness requirement in lieu of a care and treatment standard limited the amount of clinical discretion psychiatrists exercised because it provided more objective criteria to govern civil commitment . . . [and that] courts become the decision-makers as to whether patients have satisfied the civil commitment criteria.

Id.

that a mentally ill patient would benefit from treatment.[38] Psychiatrists were now required to support such certification by showing that the patient was also dangerous.[39] Judges were to examine the findings of the psychiatrists and to determine whether or not an individual was to be confined.[40]

Further, in acknowledging the need to impose a check on psychiatrists' prior unrestricted power to commit, the Supreme Court expressed its concern regarding one of the potential reasons underlying continuous civil commitment of patients who pose no threat to themselves or others.[41] The Court counseled that "[m]ere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty."[42] Therefore, previously sufficient arbitrary certification of "need for treatment," based solely on the presence of mental illness and, potentially, driven by animosity toward the mentally ill, could no longer survive the new constitutional limitations imposed on psychiatrists' power to confine.[43]

A. The Mental Illness Requirement

A successful showing of mental illness constitutes the first requirement imposed by the Supreme Court in *O'Connor* on the states' power to commit.[44] This was once again reaffirmed by the Supreme Court in *Foucha v. Louisiana*.[45] Terry Foucha was charged with aggravated burglary and illegal discharge of a firearm.[46] After he was found not guilty by reason of insanity,[47] he was committed to a mental institution for as long as psychiatrists certified that there was a basis for continuing his confinement.[48]

Four years later, a panel of psychiatrists recommended a conditional discharge, providing that "there had been no evidence of

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[38] *O'Connor*, 422 U.S. at 575.

[39] *Id.*

[40] *See* Appelbaum, *supra* note 8, at 18 (stating that "[p]hysicians and family members are no longer the sole decision makers." Now, "the judiciary is routinely involved.").

[41] *O'Connor*, 422 U.S. at 575.

[42] *Id.*

[43] *Id.*

[44] *Id.*

[45] 504 U.S. 71 (1992).

[46] *Id.* at 73.

[47] *Id.* at 74.

[48] *Id.*

mental illness since admission."[49] At trial, one of the psychiatrists, appointed to a sanity commission, testified that Foucha's prior psychosis had a temporary character and that Foucha "evidenced no signs of psychosis or neurosis and was in 'good shape' mentally."[50] Instead, the psychiatrist opined that Foucha, however, had an antisocial personality, a condition that does not constitute mental illness.[51] The State of Louisiana did not contest the absence of a mental illness.[52] The Supreme Court held that because one of the two constitutional bases for commitment was lacking, Foucha "should not be held as a mentally ill person"[53] and the State was "no longer entitled to hold him on that basis."[54]

Although the Supreme Court in *Foucha* failed to legally define mental illness, it engaged in crafting its definition in several of its other decisions.[55] The following three Supreme Court cases are essential to understanding how modern jurisprudence views mental illness.

First, in *Jones v. United States*,[56] the Court found that any mental pathology that causes an individual to commit a crime, even a non-violent one, constitutes a mental illness.[57] Michael Jones, a criminal defendant who was acquitted by reason of insanity for a misdemeanor of petit larceny, punishable by up to one year in prison, was automatically committed to a mental institution, pursuant to a District of Columbia statute.[58] The statute provided for procedural methods of obtaining release.[59] That is, whenever a judicial hearing finds, by a preponderance of the evidence, that the confined is no longer mentally ill or dangerous, the individual is entitled to be released.[60] Jones took advantage of these procedural safeguards twice, but to no avail.[61] After spending more time in civil confinement than

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[49] *Id.*

[50] *Foucha*, 504 U.S. at 75.

[51] *Id.*

[52] *Id.* at 78.

[53] *Id.* at 79.

[54] *Id.* at 78.

[55] *See, e.g.*, Jones v. United States, 463 U.S. 354 (1983); Kansas v. Hendricks, 521 U.S. 346 (1997); Kansas v. Crane, 534 U.S. 407 (2002).

[56] 463 U.S. 354 (1983).

[57] *Id.* at 364-66.

[58] *Id.* at 359-60.

[59] *Id.* at 356-58.

[60] *Id.* at 357-58.

[61] *Jones*, 463 U.S. at 360-61.

his maximum prison term had he been convicted, Jones sought an unconditional release or re-commitment pursuant to a different state statute.[62] The new statute would require the State to prove that Jones was mentally ill and dangerous by clear and convincing evidence, a higher standard of proof than was required under the statute pursuant to which he was initially committed.[63]

The question became whether or not Jones was still mentally ill.[64] The Court's finding of a presence of a mental illness relied on the determination that "[a] verdict of not guilty by reason of insanity establishes two facts: (i) the defendant committed an act that constitutes a criminal offense, and (ii) he committed the act because of mental illness."[65] The Court concluded that an individual who commits a criminal act is dangerous regardless of the non-violent nature of the committed act.[66] Further, the Court found that because the criminal individual was acquitted, such "insanity acquittal supports an inference of continuing mental illness."[67] Thus, pursuant to *Jones*, mental illness is a form of abnormality that leads an individual to commit a criminal act even if the act is non-violent in nature.[68]

Second, in its later decisions, the Supreme Court continued supplementing and shaping its definition of mental illness. For instance, in *Kansas v. Hendricks*,[69] the Court found that mental illness is a volitional control impairment that makes it almost impossible to abstain from acting in a dangerous manner.[70] The State of Kansas enacted a statute that authorized commitment of an individual suffering from a "mental abnormality" or a "personality disorder" that compels him or her to commit sexually violent acts.[71] The statute defined mental abnormality as a "congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to continue sexually violent offences in a degree constituting

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[62] *Id.* at 360.

[63] *Id.* at 358-60.

[64] *Id.* at 363.

[65] *Id.*

[66] *Jones*, 463 U.S. at 364-65.

[67] *Id.* at 366.

[68] *Id.* (providing that "someone whose mental illness was sufficient to lead him to commit a criminal act is likely to remain ill and in need of treatment").

[69] 521 U.S. 346 (1997).

[70] *Id.* at 358.

[71] *Id.* at 350 (quoting KAN. STAT. ANN. § 59-29a01).

such person a menace to the health and safety of others."[72] Kansas petitioned the state court to commit Leroy Hendricks, the defendant, who had a long history of child molestation.[73] During Hendricks's testimony, he acknowledged and agreed with his diagnosis of pedophilia, admitted to continuous sexual desires for minors, and explained that he could not suppress the urge to act on those desires when he "get[s] stressed out."[74] Hendricks was found to be a sexually violent predator and was committed to an institution.[75]

The state court determined that pedophilia falls within the definition of mental abnormality.[76] The Supreme Court agreed and found that the statute required evidence of "a present mental condition that creates a likelihood of such conduct in the future if the person is not incapacitated."[77] Thus, the Court concluded that mental abnormality is a "volitional impairment" that renders control of future dangerous behavior "difficult, if not impossible."[78]

Finally, in analyzing the same Kansas statute and its application five years later, the Supreme Court in *Kansas v. Crane*[79] altered and relaxed its previous definition of mental illness. It provided that the State was not required to prove an individual's absolute inability to control his or her own behavior.[80] Rather, the State must merely show a "special and serious lack of ability to control behavior."[81]

Thus, pursuant to these three Supreme Court decisions, to satisfy the requirement of mental illness, the State must prove several elements. First, the State has to show that the individual suffers from a form of mental pathology.[82] Second, it has to show that the mental abnormality presents a serious difficulty to that individual's ability to control his or her deviate behavior.[83] Lastly, the State must prove that the mental abnormality can induce the alleged mentally ill indi-

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[72] *Id.* at 352 (quoting KAN. STAT. ANN. § 59-29a02(b)).
[73] *Id.* at 354-55.
[74] *Hendricks*, 521 U.S. at 355.
[75] *Id.* at 355-56.
[76] *Id.*
[77] *Id.* at 357.
[78] *Id.* at 358.
[79] 534 U.S. 407 (2002).
[80] *Id.* at 411.
[81] *Id.* at 412-13.
[82] *See, e.g.*, *Jones*, 463 U.S. at 364-66.
[83] *Crane*, 534 U.S. at 413.

vidual to commit a criminal act, violent or not.[84]

B. The Dangerousness Requirement

The Supreme Court in *O'Connor* established that the State cannot confine an individual if he or she poses no danger to self or others.[85] Following this landmark decision, numerous courts reviewed state statutes that authorized detention of non-dangerous patients.[86] For example, in *Suzuki v. Yuen*,[87] the Ninth Circuit struck down a portion of Hawaii's civil commitment statute that authorized confinement of a person who was dangerous to property of any value.[88] The court acknowledged that "the state's interest in protecting property is not sufficiently compelling to warrant the curtailment of liberty brought about by involuntary commitment."[89]

Similarly, in *Doremus v. Farrell*,[90] the court invalidated Nebraska's civil commitment laws.[91] The court followed the *O'Connor* requirements and held that due process required a showing of dangerousness in addition to a showing of mental illness.[92] It recognized that "[t]o 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."[93] Currently, all fifty states incorporate *O'Connor*'s dangerousness requirement in their commitment statutes.[94] Although the requirement is on the books, in practice, it is not always adhered to.

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[84] *Id.*; *Jones*, 463 U.S. at 364-66.

[85] *O'Connor*, 422 U.S. at 575.

[86] *See* Suzuki v. Yuen, 617 F.2d 173, 178 (9th Cir. 1980); Colyar v. Third Judicial Dist. Court for Salt Lake Cnty., 469 F. Supp. 424, 432 (D. Utah 1979); Stamus v. Leonhardt, 414 F. Supp. 439, 449-51 (S.D. Iowa 1976); *Doremus*, 407 F. Supp. at 514-15; Lynch v. Baxley, 386 F. Supp. 378, 390 (M.D. Ala. 1974); Bell v. Wayne Cnty. Gen. Hosp. at Eloise, 384 F. Supp. 1085, 1096 (E.D. Mich. 1974); State ex rel. Hawks v. Lazaro, 202 S.E.2d 109, 123 (W. Va. 1974).

[87] 617 F.2d 173 (9th Cir. 1980).

[88] *Id.* at 176.

[89] *Id.*

[90] 407 F. Supp. 509 (1975).

[91] *Id.* at 517.

[92] *Id.* at 514-15.

[93] *Id.* at 514.

[94] *See infra* notes 101-11.

C. Practical Reasons Why *O'Connor*'s Dangerousness Requirement Routinely Is Overlooked

O'Connor's dangerousness requirement is not without its flaws.[95] These flaws constitute some reasons why the dangerousness requirement routinely is overlooked in practice. Fortunately, it is possible to strengthen the weaknesses that surround this constitutional standard.

1. Lack of Precise Definition of What Constitutes Danger

The first, and likely the most significant, reason why *O'Connor*'s dangerousness requirement routinely is disregarded in practice is due to the vagueness of the concept of danger.[96] Although courts and states have attempted to define what constitutes danger,[97] there is still ambiguity as to what it involves.[98] Most states define dangerousness as a risk of harm to self or others.[99] Yet, many states disagree about the required degree of risk needed to reach the level of dangerousness.[100] Currently, the varying levels of dangerousness among the states include: substantial risk,[101] clear and present

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[95] Grant H. Morris, *Defining Dangerousness: Risking a Dangerous Definition*, 10 J. CONTEMP. LEGAL ISSUES 61, 66 (1999) (discussing that although the dangerousness standard is currently tolerable, it is just as vague as the intolerable "need for treatment" requirement).

[96] *See* Brooks, *supra* note 6, at 264-65.

[97] *See, e.g.*, *Jones*, 463 U.S. at 364 (declaring that "[t]he fact that a person has been found, beyond a reasonable doubt, to have committed a criminal act certainly indicates dangerousness"); People v. Stevens, 761 P.2d 768, 772-74 nn.4-8 (Colo. 1988) (discussing the difference in states' definitions of dangerousness).

[98] *See* Brooks, *supra* note 6, at 291-94 (explaining some of the consequences caused by the vagueness of the definition of danger); John Monahan, *A Jurisprudence of Risk Assessment: Forecasting Harm among Prisoners, Predators, and Patients*, 92 VA. L. REV. 391, 401 (2006) (discussing some changes in statutory commitment standards); Morris, *supra* note 95, at 70-71 (discussing the difference in defining harm and probability of its occurrence across the states).

[99] *See infra* notes 101-11.

[100] *See, e.g.*, *Stevens*, 761 P.2d at 772-73 nn.4-8.

[101] ALASKA STAT. ANN. § 47.30.915 (West 2013) (substantial risk); COLO. REV. STAT. ANN. § 27-65-102 (West 2013) (substantial risk); CONN. GEN. STAT. ANN. § 17a-495 (West 2009) (substantial risk); GA. CODE ANN. § 37-3-1 (West 2010) (substantial risk of imminent harm); IDAHO CODE ANN. § 66-317 (West 2008) (substantial risk); ME. REV. STAT. tit. 34-B, § 3801 (West 2010) (substantial risk); MASS. GEN. LAWS ANN. ch. 123, § 1 (West 1989) (substantial risk); MO. ANN. STAT. § 632.005 (West 2011) (substantial risk); NEB. REV. STAT. § 71-908 (West 2004) (substantial risk); N.C. GEN. STAT. ANN. § 122C-3 (West 2013) (reasonable probability or substantial risk); OHIO REV. CODE ANN. § 5122.01 (West 2013) (sub-

threat,[102] substantial physical harm,[103] substantial likelihood of harm,[104] substantial likelihood of physical harm,[105] substantial likelihood of serious harm,[106] likelihood of serious harm,[107] demonstrated danger,[108] likely to cause harm,[109] and reasonable expectation of harm.[110] Very few states insist on imminent threat.[111] Some courts incorporated into their definition a requirement of a recent overt act

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stantial risk); OKLA. STAT. ANN. tit. 43A, § 1-103 (West 2013) (poses a substantial risk of immediate physical harm); R.I. GEN. LAWS ANN. § 40.1-5-2 (West 2006) (substantial risk).

[102] ALA. CODE § 22-52-10.4 (West 1991) (real and present threat of substantial harm); DEL. CODE ANN. tit. 16, § 5001 (West 2011) (real and present threat); FLA. STAT. ANN. § 394.467 (West 2009) (real and present threat of substantial harm to self or substantial likelihood of harm to others); MD. CODE ANN., HEALTH-GEN. § 10-622 (West 2010) (presents a danger); 50 PA. STAT. ANN. § 7301 (West 1978) (clear and present danger of harm).

[103] KY. REV. STAT. ANN. § 202A.011 (West 2012) (substantial physical harm).

[104] N.D. CENT. CODE ANN. § 25-03.1-02 (West 2011) (substantial likelihood of harm).

[105] MINN. STAT. ANN. § 253B.02 (West 2013) (substantial likelihood of physical harm); MISS. CODE. ANN. § 41-21-61 (West 2010) (substantial likelihood of physical harm); WIS. STAT. ANN. § 51.20 (West 2012) (substantial probability of physical harm).

[106] TENN. CODE ANN. § 33-6-401 (West 2001) (substantial likelihood of serious harm).

[107] N.Y. MENTAL HYG. LAW § 9.37 (McKinney Supp. 2014) (likely to result in serious harm); S.C. CODE ANN. § 44-17-580 (West 2005) (likelihood of serious harm); WASH. REV. CODE ANN. § 71.05.150 (West 2011) (likelihood of serious harm).

[108] CAL. WELF. & INST. CODE § 5300 (West 1983) (demonstrated danger).

[109] D.C. CODE § 21-545 (West 2004) (likely to injury himself or others); IOWA CODE ANN. § 229.1 (West 2012) ("likely to physically injure the person's self or others"); KAN. STAT. ANN. § 59-2946 (West 2012) (likely to cause harm); NEV. REV. STAT. ANN. § 433A.160 (West 2007) (likely to harm himself or herself or others); N.H. REV. STAT. ANN. § 135-C:34 (West 2014) (create[s] a potentially serious likelihood of danger); N.J. STAT. ANN. § 30:4-27.2 (West 2010) (probable; substantial likelihood); N.M. STAT. ANN. § 43-1-3 (West 2013) (more likely than not); TEX. HEALTH & SAFETY CODE ANN. § 574.034 (West 2013) (likely to cause serious harm); VA. CODE ANN. § 37.2-815 (West 2010) (likelihood that the person will, in the near future, suffer serious harm or cause serious harm to himself or others); W. VA. CODE ANN. § 27-5-3 (West 2006) (likely to cause serious harm); WYO. STAT. ANN. § 25-10-101 (West 2011) (substantial probability).

[110] ARK. CODE ANN. § 20-47-207 (West 2009) (reasonable probability); ARIZ. REV. STAT. ANN. § 36-501 (West 2012) (can reasonably be expected to result in serious physical harm); 405 ILL. COMP. STAT. ANN. 5/1-119 (West 2010) (reasonably expected to engage in conduct placing such person or another in physical harm or in reasonable expectation of being physically harmed); LA. REV. STAT. ANN. § 28:2 (West 2013) (reasonable expectation that there is a substantial risk that he will inflict physical harm upon another person in the near future); MICH. COMP. LAWS ANN. § 330.1401 (West 2005) (can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself, herself, or another individual); S.D. CODIFIED LAWS § 27A-1-1 (West 2011) (a reasonable expectation that the person will inflict serious physical injury upon himself, herself or another person in the near future).

[111] HAW. REV. STAT. § 334-60.2 (West 2014) (imminently dangerous); MONT. CODE ANN. § 53-21-126 (West 2005) (imminent threat); UTAH CODE ANN. § 62A-15-602 (West 2012) (at serious risk).

of violence toward self or others, while other courts did not.[112] The existence of these varying standards indicates that there is no agreement among the states about what dangerousness entails. However, because "[t]here is no requirement . . . that due process of law must be the same in all fifty states,"[113] the states are free to provide their own definitions and impose additional requirements, if any.[114] Unfortunately, individual states and their courts continuously fail to craft definitions that would encompass all aspects of danger.

The absence of a clear understanding for what is deemed "dangerous" allows committing psychiatrists to rely on their clinical judgments and categorize reported symptoms to fit into the existing statutory definitions.[115] This works to the detriment of the mentally ill because today's extensive research shows that clinical judgments are very faulty when it comes to assessing danger.[116] Typically, reliance on clinical judgments results in over-predictions[117] and, hence, wrongful confinements of non-dangerous individuals. The truth is, so long as states and courts fail to provide well-crafted definitions of

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[112] *Compare Colyar*, 469 F. Supp. at 434 (overt act is not required), *and* United States *ex rel.* Mathew v. Nelson, 461 F. Supp. 707, 710 (N.D. Ill. 1978) (same), *and* Project Release v. Prevost, 722 F.2d 960, 973-74 (2d Cir. 1983) (same), *and In re* Scopes, 398 N.Y.S.2d 911, 913 (App. Div. 3d Dep't 1977) (same), *with Suzuki*, 617 F.2d at 178 (overt act is required), *and Stamus*, 414 F. Supp. at 451 (same), *and Doremus*, 407 F. Supp. at 514-15 (same). *See also Lynch*, 386 F. Supp. at 391 (overt act is required); Lessard v. Schmidt, 349 F. Supp. 1078, 1093 (E.D. Wis. 1972).

[113] *Stevens*, 761 P.2d at 773.

[114] *Addington*, 441 U.S. at 431.

[115] *See* Brooks, *supra* note 6, at 265 (providing that "[t]he absence of . . . clarifying concepts, which would limit the discretion of the civil commitment evaluators, provides an opportunity for psychiatrists to label individuals as dangerous when the doctors wish to confine people deemed to be in need of treatment").

[116] *See, e.g.*, Alexander Scherr, *Daubert & Danger: The "FIT" of Expert Predictions in Civil Commitments*, 55 HASTINGS L.J. 1, 17 (2003) (explaining that "[c]linical opinions have never received high marks for reliability"); Donald H. Stone, *Confine Is Fine: Have the Non-Dangerous Mentally Ill Lost Their Right to Liberty? An Empirical Study to Unravel the Psychiatrist's Crystal Ball*, 20 VA. J. SOC. POL'Y & L. 323, 337 (2012):

> For years, the conventional wisdom was that clinicians were rather poor at predicting future violence in individuals with mental disorders. In general, studies showed that clinicians were right a third of the time in predicting whether an individual with mental illness would be involved in future violence. The standard conclusion was that relying on clinical experience was not appreciably better than flipping a coin.

Id.

[117] *See Jones*, 463 U.S. at 378 (Brennan, J., dissenting) (emphasizing that "[c]ommentators and researchers have long acknowledged that even the best attempts to identify dangerous individuals on the basis of specified facts have been inaccurate roughly two-thirds of the time, almost always on the side of over-prediction").

what danger entails, psychiatrists will continue to adopt their personalized definitions of danger and rely on their clinical judgments to commit patients who they find to be in "need of treatment" precisely on that basis—the basis abolished over forty years ago.[118] Therefore, states and courts are urged to develop precise definitions of danger that would entail all possible aspects of this concept: level of likelihood, time proximity, and required degree of harm.[119]

2. Absence of Legal Requirement to Utilize Actuarial Methods of Assessment for Danger

The second reason why courts repeatedly overlook *O'Connor*'s dangerousness requirement stems from the lack of a requirement legally imposed on psychiatrists, which would require them to adhere to scientifically developed, reliable instruments for assessing danger.[120] There is no doubt that psychiatry is not a precise science.[121] However, it is still a science with its own knowledge, methods, and techniques. Unfortunately, even though today's psychiatrists mastered their diagnostic skills, studies show that they remain non-proficient in their ability to assess for dangerousness.[122] Irrespective of these findings, committing mental health professionals continue to disregard existing and reliable actuarial assessment tools, such as, "Violence Risk Appraisal Guide," "The HCR-20," and "The Classification of Violent Risk," that can help them to ensure accurate conclusions.[123]

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[118] *See* Brooks, *supra* note 6, at 265 (providing that "[d]octors want to treat people deemed to require care and treatment, and if they must certify a patient as dangerous in order to facilitate treatment, doctors will do so"); *see also* Robert I. Simon, *Imminent Suicide: The Illusion of Short-Term Prediction*, 36(3) SUICIDE AND LIFE-THREATENING BEHAVIOR 296, 298 (2006) (discussing that the vague definition of danger can lead committing psychiatrists to err on the side of caution and involuntarily hospitalize patients).

[119] *See Brooks*, *supra* note 6, at 265 (calling for incorporation of "all of the components of a dangerousness determination: probability, imminence, and magnitude of harm to person").

[120] *Id.* at 263.

[121] *See Addington*, 441 U.S. at 430 (explaining that "[t]he subtleties and nuances of psychiatric diagnosis render certainties virtually beyond reach in most situations").

[122] *See supra* note 118 and accompanying text.

[123] *See* Monahan, *supra* note 98, at 408-13. First, defining "actuarial (or statistical) prediction" as the one that "relies on explicit rules specifying which risk factors are to be measured, how those risk factors are to be scored, and how the scores are to be mathematically combined to yield an objective estimate of violence risk." *Id.* at 405-06. Second, describing three best-known actuarial assessment instruments. *Id.* at 409-13. One of the assessment tools is known as "Violence Risk Appraisal Guide," and consists of nine categories that are based on twelve variables. *Id.* at 409-10. A recent study showed that only eleven percent of

Such resistance to advance psychiatrists' professional ability to accurately assess for dangerousness comes at a steep price. An incorrect conclusion, which typically involves over-prediction,[124] or labeling a non-dangerous mentally ill individual as dangerous, can infringe upon the mentally ill individual's constitutional right to liberty.[125] An incorrect finding of dangerousness wrongfully triggers satisfaction of the *O'Connor* criteria, thus allowing involuntary confinement of a non-dangerous individual.[126]

The failure of states and courts to legally require psychiatrists to utilize actuarial methods of assessment allows psychiatrists to continue playing an overly influential and decisive role in civil commitments.[127] Because psychiatrists continue to rely solely on their professional experiences and clinical judgments, courts will have no way to carefully scrutinize the accuracy of the psychiatrists' assessments. Thus, as a practical matter, even though the Supreme Court replaced the old, "need for treatment," subjective standard with what was intended to be a more objective requirement of dangerousness, psychiatrists retain their unrestricted unilateral power to commit individuals. Courts and states are encouraged to explore a possibility of requiring mental health professionals to rely on more objective, reliable and empirically proven methods of assessment for dangerousness.

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the study participants, who scored in the first category, later committed a new violent act as opposed to forty-two percent of the participants in category five, and one hundred percent of the participants in category nine. *Id.* at 410. The second assessment tool is called "The HCR-20," and consists of twenty ratings. Monahan, *supra* note 98, at 410-11. A recent study found that when participants' scores were separated into five distinct categories, only eleven percent of the patients placed in the lowest category "were found to have committed or threatened a physically violent act," as opposed to forty percent of the participants placed in the middle category and seventy-five percent of the participants placed in the highest category. *Id.* at 411. Lastly, the Classification of Violent Risk places participants into "one of five risk classes." *Id.* at 411-13. Only one percent of the patients in the first risk class committed a violent act within twenty weeks after their discharge from a psychiatric facility as compared with seventy-six percent of the participants who were placed in the highest risk class. *Id.* at 412-13.

[124] *See supra* note 117.

[125] *See O'Connor*, 422 U.S. at 576 (providing that only successful showing of mental illness and dangerousness can constitutionally justify one's civil commitment).

[126] *Id.*

[127] *See* Brooks, *supra* note 6, at 263 (suggesting that "psychiatrists still exercise . . . an inordinate amount of influence on the civil commitment process").

3. Heavy Reliance by Judges on Psychiatrists' Expert Testimony during Commitment Hearings

The disregard of *O'Connor*'s dangerousness requirement is also demonstrated during commitment hearings. Judges disregard the fact that one of *O'Connor*'s main objectives was to transfer decision-making power from psychiatrists to judges.[128] To do so, judges were to analyze psychiatrists' findings of mental illness and dangerousness.[129] However, irrespective of what *O'Connor* urged courts to do, judges routinely make their commitment rulings by deferring to committing psychiatrists' expert testimony given during hearings.[130] It is especially troubling for the judges to rely solely on clinical judgments given that judges are well aware of psychiatrists' inability to make correct dangerousness assessments.[131]

Courts are urged not to give extensive deference to committing psychiatrists' expert opinions during commitment hearings.[132] Rather, courts should consider utilizing an independent expert testimony to offer the mentally ill an opportunity to contest psychiatrists' possibly erroneous findings. Such a vehicle for questioning and testing of committing psychiatrists' assessments can help to prevent the commitment of those who pose no danger to themselves or others.

4. Liability Concern and Lack Thereof

Liability concerns can certainly influence one's professional behavior. When it comes to psychiatrists' liability concerns, they face two major issues. On the one hand, psychiatrists are greatly concerned with potential liability for letting a dangerous individual

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[128] *Id.*

[129] *Id.*

[130] *See id.* at 259 (stating that "[j]udges continue to defer, almost blindly, to expert testimony").

[131] *See Jones*, 463 U.S. at 378 (Brennan, J., dissenting); *see also Project Release*, 722 F.2d at 973 (acknowledging that "the medical profession's ability to predict dangerousness . . . is hotly debated").

[132] *See* Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES 37, 41-42 (1999) (providing that "[i]n practice, commitment hearings tend to be brief and non-adversarial episodes in which judges appear to 'rubber stamp' the recommendations of clinical expert witnesses. Indeed, studies show judicial agreement with expert witnesses in this area ranges from seventy-nine to one hundred percent, and most frequently exceeds ninety-five percent.").

free.[133] This concern dictates their desire to err on the side of caution and commit non-dangerous individuals.[134]

On the other hand, psychiatrists rarely face any liability for confining non-dangerous individuals because very few wrongfully confined individuals challenge their commitments.[135] The brave "[i]nmates of mental institutions"[136] who attempt to challenge their wrongful civil commitments quickly learn that the existing legal standards, under which their claims are reviewed, are one-sided and overly protective of the mental health professionals acting on behalf of the state, rather than of those who suffered liberty deprivations.[137] While the presently employed standards ensure that it would be difficult for the plaintiff to prevail,[138] they fail to incorporate the constitutional protections afforded to the mentally ill by *O'Connor*.

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[133] *See* Brooks, *supra* note 6, at 275 (stating that "[t]he psychiatrist who fails to accurately assess a dangerous patient and authorizes the release or suggests a court release a mentally ill individual who subsequently engages in harm-causing behavior will be subject to severe criticism").

[134] *Id.* Brooks explains that:

> [A] concern for liability can impact a clinician's decision-making in the commitment context because it can create a conflict with the goal of committing only those individuals who, after a careful assessment and application of clinically appropriate criteria, meet the commitment standard. When this occurs, clinicians err on the side of protection from liability.

Id.

[135] *Id.* at 275-76. For example:

> [I]f the psychiatrist incorrectly assesses a nondangerous individual as dangerous, he will suffer no consequences. The psychiatrist's assessment of likely harm-causing behavior cannot be challenged because no one knows whether harm would have occurred if the doctor did not authorize coercive clinical intervention. Thus, both the public and the committing psychiatrist will rarely, if ever, learn about an incorrect assessment of dangerousness, but they will always learn about an incorrect assessment of nondangerousness.

Id.

[136] *Jones*, 463 U.S. at 384.

[137] *See* Simon, *supra* note 118, at 298 (acknowledging psychiatrists' understanding of lack of liability for wrongful civil commitment so long as it was a good faith mistake).

[138] *See, e.g.*, Levinson, *supra* note 16, at 559 (urging that "[a]n examination of *Lewis* and its progeny demonstrates that the Supreme Court's adoption of the shocks-the-conscience standard for substantive due process violations has imposed a nearly insurmountable obstacle to holding government officials responsible for their abuses of power").

III. THE FEDERAL COMMON LAW EVOLUTION OF TWO COMPETING STANDARDS UTILIZED IN THE IMPOSITION OF LIABILITY ON STATE ACTORS FOR WRONGFUL CIVIL COMMITMENTS

Currently, there are only four circuits[139] that have decided what standard should govern the imposition of liability on psychiatrists, acting on behalf of the state, in challenges to wrongful civil commitments. These circuits are split on the issue of which standard should prevail.[140] This disagreement does not involve their shared failure to incorporate the *O'Connor* requirements into their standards.

A. The Third and Tenth Circuits

The Third and the Tenth Circuits adopted the "shocks-the-conscience" standard, a standard that was announced by the Supreme Court in *County of Sacramento v. Lewis*.[141] Under this *Lewis* standard, a psychiatrist would be liable for wrongful civil commitment only if his or her decision to commit shocked-the-conscience.[142] There are several important aspects of *Lewis* that need to be clarified.

First, *Lewis* did not involve a challenge to one's civil confinement.[143] Rather, *Lewis* involved the establishment of a "standard of culpability on the part of a law enforcement officer for violating substantive due process in a pursuit case."[144] The case stemmed from a high-speed police pursuit of two teenagers on a motorcycle that resulted in the death of one of the youths.[145] The parents of the deceased boy brought a lawsuit claiming that the police officers violat-

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[139] *See Benn*, 371 F.3d 165; *Bolmer*, 594 F.3d 134; *Jensen*, 312 F.3d 1145; *Rodriguez*, 72 F.3d 1051; *Obado*, 524 F. App'x 812; *James*, 1998 WL 664315, at *1 (representing the Second, Third, Ninth and Tenth Circuits, respectively).

[140] *Compare Rodriguez*, 72 F.3d at 1063 (imposing liability on state psychiatrists for wrongful civil commitments only if the committing mental health professional's decision to confine was made on the basis that is "substantially below the standards generally accepted in the medical community"), *Bolmer*, 594 F.3d at 143 (same), *and Jensen*, 312 F.3d at 1147 (same), *with Benn*, 371 F.3d at 174 (imposing liability on state psychiatrists only if their decision to commit, under the circumstances, "shocks the conscience"), *Obado*, 524 F. App'x at 815 (same), *and James*, 1998 WL 664315, at *7 (same).

[141] 523 U.S. 833 (1998).

[142] *See Benn*, 371 F.3d at 174; *Obado*, 524 F. App'x at 815; *James*, 1998 WL 664315, at *7.

[143] *See Lewis*, 523 U.S. 833 (1998).

[144] *Id.* at 839.

[145] *Id.* at 836-37.

ed their son's Fourteenth Amendment right to life.[146]

The district court granted summary judgment for the police officer on the theory of qualified immunity.[147] The Court of Appeals for the Ninth Circuit reversed and established that "the appropriate degree of fault to be applied to high-speed police pursuits is deliberate indifference to, or reckless disregard for, a person's right to life and personal security."[148] In rejecting the standard established by the Ninth Circuit, the Supreme Court announced that the only "level of executive abuse of power" that violates substantive due process rights is one that "shocks the conscience."[149] Furthermore, the Court declared, "only the most egregious executive action can be said to be 'arbitrary' in the constitutional sense."[150]

Second, it is vital to understand the significance of *Lewis*. *Lewis* did not merely establish a new standard—it went beyond that.[151] It created an entire framework for analyzing imposition of liability for the State's wrongful conduct.[152] It provided that "[t]he conscience-shocking concept points clearly away from liability, or clearly toward it, only at the ends of the tort law's culpability spectrum."[153] To demonstrate this, the Court held that mere negligence on the part of the State does not shock the conscience and does not trigger the imposition of liability.[154]

However, when the state official's conduct stems from the middle range of the culpability spectrum, such as recklessness or gross negligence, the Supreme Court held that such conduct requires a more careful investigation.[155] The Court provided for a possibility

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[146] *Id.* at 837.

[147] *Id.* at 837-38.

[148] *Lewis*, 523 U.S. at 838 (quoting Sacramento Cnty. v. Lewis, 98 F.3d 434, 441 (9th Cir. 1996)).

[149] *Id.* at 846.

[150] *Id.* at 834.

[151] *See Bolmer*, 594 F.3d at 142 (explaining that "[t]he Court indicated . . . that the shocks-the-conscience inquiry is not a stand-alone test for determining whether particular executive conduct violates substantive due process; rather, it provides a framework for making such a determination").

[152] *Id.*

[153] *Lewis*, 523 U.S. at 834.

[154] *Id.* (providing that "[l]iability for negligently inflicted harm is categorically beneath the constitutional due process threshold").

[155] *Id.* at 849 (providing that "[w]hether the point of the conscience shocking is reached when injuries are produced with culpability falling within the middle range, following from something more than negligence but 'less than intentional conduct, such as recklessness or gross negligence,' is a matter for closer calls").

of imposition of liability[156] and emphasized that "some official acts in this range may be actionable under the Fourteenth Amendment."[157] The Court explained that "[r]ules of due process are not . . . subject to mechanical application"[158] because "[d]eliberate indifference that shocks in one environment may not be so patently egregious in another."[159] To determine whether liability is to follow, the Court called for "an exact analysis of circumstances before any abuse of power is condemned as conscience shocking."[160]

When it comes to intentional conduct on the part of state officials, the Court held that "conduct deliberately intended to injure . . . is the sort of official action most likely to rise to the conscience-shocking level."[161] Civil commitment involves intent in its clearest form.[162] For example, the court in *Demarco v. Sadiker*[163] acknowledged that liberty deprivation through civil commitment is "the result of a[n] . . . intentional act of confinement."[164] Thus, pursuant to *Lewis*, an intentional act of civil commitment that lacked a constitutional basis of mental illness and dangerousness would result in the imposition of liability. Unfortunately, the courts which adopted the standard are yet to conform to this analysis.

For instance, in 2004, in *Benn v. Universal Health System, Inc.*,[165] the Third Circuit addressed the issue of the governing standard in actions for liability resulting from wrongful civil commitments.[166] Donald Benn brought an action against those involved in his short-term involuntary confinement.[167] Among several allegations, one involved a concern that the examining psychiatrists fol-

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156 *Id.*

157 *Id.*

158 *Lewis*, 523 U.S. at 850.

159 *Id.*

160 *Id.*

161 *Id.* at 834.

162 *See, e.g.*, Demarco v. Sadiker, 897 F. Supp. 693, 702 (E.D.N.Y. 1995) (holding that "where . . . a plaintiff alleges that he was intentionally committed to a mental hospital without the requisite finding of dangerousness and/or without his actually being dangerous, he has sufficiently plead the *mens rea* requirement of a § 1983 cause of action based upon a due process violation").

163 897 F. Supp. 693 (E.D.N.Y. 1995).

164 *Id.* at 700.

165 371 F.3d 165 (3d Cir. 2004).

166 *Id.* at 174.

167 *Id.* at 167.

lowed a "seriously defective evaluative process,"[168] which led them to conclude that Benn met the criteria for emergency confinement.[169] On appeal from summary judgment granted to the defendants, the Third Circuit provided that "[i]n a due process challenge to executive action, the threshold question is whether the behavior of the governmental officer is so egregious, so outrageous, that it may fairly be said to shock the contemporary conscience."[170]

In adopting the *Lewis* approach, the Third Circuit also expressed that "whether or not . . . [the psychiatrists] properly analyzed Benn's condition, their conduct did not violate substantive due process."[171] In other words, the court held that regardless of a possible inaccuracy of the psychiatrists' determination of Benn's dangerousness, the order to commit a non-dangerous or non-mentally ill patient did not shock the conscience.[172] This conclusion again avoids constitutional protections afforded to the mentally ill by *O'Connor*. In 2013, the Third Circuit, in *Obado v. UMDNJ, Behavioral Health Center*,[173] reaffirmed that "the appropriate test for assessing liability in the context of involuntary commitment decisions is the 'shocks the conscience' standard announced in *Lewis*."[174] Similar to the court in *Benn*, the court in *Obado* did not find the psychiatrists' intentional act of commitment conscience-shocking.[175]

In 1998, the Tenth Circuit also adopted the *Lewis* standard.[176] In *James v. Grand Lake Mental Health Center, Inc.*,[177] Jeannie James brought an action against nine defendants for her wrongful civil commitment.[178] The district court dismissed all of her claims.[179] The Tenth Circuit affirmed the lower court's decision and held that the alleged conduct by the defendants did not rise to the level of conscience shocking and, thus, did not violate James's substantive due

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168 *Id.* at 172.

169 *Id.*

170 *Benn*, 371 F.3d at 174 (citing *Lewis*, 523 U.S. at 847).

171 *Id.* at 175.

172 *Id.*

173 524 Fed. App'x. 812 (3d Cir. 2013), *cert. denied*, 134 S. Ct. 986 (2014).

174 *Id.* at 815.

175 *Id.*

176 *See James*, 1998 WL 664315, at *7 (holding that plaintiff's "allegations would not rise to the "shocks the conscience" standard articulated by the Supreme Court for substantive due process claims").

177 No. 97-5157, 1998 WL 664315 (10th Cir. Sept. 24, 1998).

178 *Id.* at *1.

179 *Id.* at *2.

process rights.[180] Unfortunately, this circuit also failed to incorporate the *O'Connor* requirements of mental illness and dangerousness, thus failing to provide protections to non-dangerous individuals.

B. The Second and Ninth Circuits

The Second Circuit was the first to decide what standard should govern when imposing liability on state psychiatrists for wrongful civil commitments. This court was also the first to depart from *O'Connor*'s dangerousness analysis. Instead, the court adopted a standard that heavily resembles the standard announced by the Supreme Court in *Youngberg v. Romeo*[181] in 1982.[182] As a result, in 1995, the Second Circuit, in *Rodriguez v. City of New York*,[183] established that only where the psychiatrist's commitment decision is based on criteria that are "substantially below the standards generally accepted in the medical community," or, in other words, the decision to commit was grossly negligent, will liability follow.[184]

In 1993, Florangel Rodriguez commenced an action challenging her emergency, involuntary, short-term civil confinement, when the evaluating psychiatrists concluded that "[s]he . . . [was] a potential danger to herself and would benefit from hospitalization."[185] Rodriguez vigorously contested these clinical conclusions, alleging that

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[180] *Id.* at *7.

[181] 457 U.S. 307 (1982).

[182] In *Youngberg*, the Court explored the substantive due process rights of institutionalized patients within an institution and state actions that violated those rights. *Id.* at 309. Nicholas Romeo, while permanently committed to a state institution, allegedly sustained injuries on at least sixty-three occasions, during the duration of his civil commitment. *Id.* at 310. His mother brought a suit challenging the conditions of his confinement. *Id.* The Court emphasized that Romeo "does not challenge the commitment" and "neither respondent nor his family seeks his discharge from state care." *Id.* at 315, 329. Rather, they alleged that Romeo had a substantive due process right to safety, freedom of movement, and training within the institution. *Youngberg*, 457 U.S. at 315. They further alleged that these rights were violated by the officials' failure to meet such constitutional requirements of civil commitment. *Id.* The Supreme Court established that one's "liberty interests require the State to provide minimally adequate or reasonable training to ensure safety and freedom from undue restraint." *Id.* at 319. However, "liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment." *Id.* at 323.

[183] 72 F.3d 1051 (2d Cir. 1995).

[184] *See id.* at 1063 (finding that "whether an individual is to be summarily deprived of her liberty—be exercised on the basis of substantive and procedural criteria that are not substantially below the standards generally accepted in the medical community").

[185] *Id.* at 1055.

the medical entries by the examining psychiatrists "in many respects inaccurately or incompletely depicted the statements made by Rodriguez"[186] and that the psychiatrists "took Rodriguez's statements out of context."[187] She further contested the durations of her examinations and the manner in which they were conducted.[188] Lastly, plaintiff provided competing clinical findings and testimony by an independent psychiatrist who concluded that the examination by the committing mental health professionals was full of "glaring errors."[189] Such errors ranged from examining Rodriguez for suicidal risk for an insufficient amount of time to failing to inquire into the truthfulness of some of the statements that she allegedly made.[190]

The trial court granted summary judgment to the state defendants.[191] On appeal, the Second Circuit vacated the trial court's decision and remanded the case.[192] To guide lower courts in similar proceedings, the court declared that a physician's "judgment—affecting whether an individual is to be summarily deprived of her liberty—be exercised on the basis of substantive and procedural criteria that are not substantially below the standards generally accepted in the medical community. Due process requires no less."[193]

Fifteen years later, in 2010, the Second Circuit had an opportunity to revisit *Rodriguez*. In *Bolmer v. Oliveira*,[194] the court reaffirmed that "an involuntary commitment violates substantive due process if the decision to commit is made on the basis of 'substantive and procedural criteria that are . . . substantially below the standards generally accepted in the medical community.' "[195] Bolmer was committed on an involuntary and emergency basis following his evaluation that lasted somewhere between five and fifteen[196] minutes by the psychiatrist who was never previously involved in his care.[197]

Brett Bolmer alleged sexual involvement with his case man-

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[186] *Id.*
[187] *Id.* at 1056.
[188] *Rodriguez*, 72 F.3d at 1055-56.
[189] *Id.* at 1056.
[190] *Id.* at 1056-57.
[191] *Id.* at 1053.
[192] *Id.* at 1066.
[193] *Rodriguez*, 72 F.3d at 1063.
[194] 594 F.3d 134 (2d Cir. 2010).
[195] *Id.* at 139 (citing *Rodriguez*, 72 F.3d at 1063).
[196] *Id.* at 138.
[197] *Id.*

ager, who he had known personally, prior to the beginning of their professional relationship.[198] The treatment team did not believe the allegations[199] and attributed them to Bolmer's manifestation of "erotomania,"[200] a form of delusion. Bolmer's psychiatric evaluation followed and, as a result, he was transported to a hospital where he was strapped to the bed and administered anti-psychotic medication.[201] When the hospital staff discovered numerous text messages between Bolmer and his case manager and confirmed the existence of communication between the two, Brett Bolmer was discharged.[202] He brought a lawsuit alleging a violation of his substantive due process rights.[203]

The defense argued that *Rodriguez* did not govern the issue because it was decided in 1995, prior to *Lewis*.[204] Rather, the defense argued that *Lewis*, decided by the Supreme Court three years after *Rodriguez*, should become the principal standard. The Second Circuit in *Bolmer* was faced with the task of reconciling the two standards.[205]

The court responded to the defense's argument for adoption of *Lewis* by declaring that "the shocks-the-conscience inquiry is not a stand-alone test for determining whether particular executive conduct violates substantive due process."[206] Rather, such determination should be based on specific surrounding context.[207] The Second Circuit held that the decision of a physician "to involuntarily commit a mentally ill person because he poses a danger to himself or others shocks the conscience, thereby violating substantive due process, when the decision is based on 'substantive and procedural criteria that are . . . substantially below the standards generally accepted in

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[198] *Id.* at 137.

[199] *Bolmer*, 594 F.3d at 137-38.

[200] *Id.*

[201] *Id.* at 138.

[202] *Id.*

[203] *Id.* at 139.

[204] *See Bolmer*, 594 F.3d at 137 ("Oliveira argues that the medical-standards test . . . is inconsistent with [*Lewis*]" because "it imposes liability for conduct that does not 'shock the conscience.' ").

[205] *See Bolmer*, 594 F.3d at 143 (addressing Oliveira's contention that "the district court erred by applying *Rodriguez*'s medical-standards test instead of determining whether Oliveira's conduct shocked the conscience under *Lewis*").

[206] *Id.* at 142.

[207] *Id.* at 142-43.

the medical community.' "[208] Therefore, since *Rodriguez* imposes liability for the conduct that, at a minimum, can be classified as grossly negligent[209] and *Lewis* does not preclude liability for such a middle-range culpability level,[210] the court found that "*Rodriguez* is consistent with *Lewis*."[211]

In adhering to the standard that essentially resembles *Youngberg*, another Supreme Court decision that will be discussed later, the Second Circuit departed from what *O'Connor* urged the courts to do, namely, to analyze whether or not the individual who allegedly suffered a deprivation of liberty was mentally ill and dangerous at the time of his or her commitment.[212] Instead, the court implemented a standard that would inquire whether the decision to commit was made on the basis that is "substantially below the standards generally accepted in the medical community[,]" or, in other words, whether the psychiatrist's level of culpability reached the required level of gross negligence for liability to follow.[213] Similar to the Second Circuit, in 2002, the Ninth Circuit in *Jensen v. Lane County*[214] also adopted the standard announced in *Rodriguez*.[215]

C. Reasons for Incorporating *O'Connor's* Dangerousness Requirement into the Two Existing Legal Standards.

There are several reasons why federal courts should incorporate *O'Connor*'s dangerousness requirement into their existing legal standards. First, the two Supreme Court decisions, *Lewis* and *Youngberg*, which constitute bases for currently employed standards, are not quite on point nor are they relevant to wrongful commitment challenges. For example, the Second and Ninth Circuits' standard of "substantially below the standards generally accepted in the medical community," or in other words, a gross negligence standard, resembles the standard announced by the Supreme Court in *Youngberg*.[216]

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[208] *Id.* at 143 (quoting *Rodriguez*, 72 F.3d at 1063).
[209] *Id.* at 144.
[210] *Lewis*, 523 U.S. at 849.
[211] *Bolmer*, 594 F.3d at 137.
[212] *O'Connor*, 422 U.S. at 576.
[213] *Rodriguez*, 72 F.3d at 1063.
[214] 312 F.3d 1145 (9th Cir. 2002).
[215] *Id.* at 1147.
[216] *See, e.g.*, *Rodriguez*, 72 F.3d at 1063; *Bolmer*, 594 F.3d at 143; *Jensen*, 312 F.3d at

The plaintiff in *Youngberg* did not challenge his confinement.[217] Rather, he challenged conditions of his confinement.[218] Therefore, a gross negligence standard is more appropriate in challenges to confinement conditions, such as right to treatment. In other words, the government should not be held to the same standard when it provides something, such as institutional care, as when it takes something away. This especially holds true when what the government is taking away involves a fundamental right.

The *Lewis* "shocks-the-conscience" standard, adopted by the Third and the Tenth Circuits, resulted from the case in which the defendant police officers had "*no intent* to harm suspects physically or to worsen their legal plight."[219] Unlike the police officers in *Lewis* who unintentionally engaged in a deadly chase, psychiatrists always commit with intent[220] and *O'Connor* pertains precisely to this level of culpability spectrum.[221]

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[217] *Youngberg*, 457 U.S. at 315 (emphasizing that the plaintiff did "not challenge the commitment"); *see id.* at 329 (Burger, J., concurring) (reiterating that the plaintiff did not seek "his discharge from state care").

[218] *Id.* at 315 (explaining that the plaintiff-respondent "argues that he has a constitutionally protected liberty interest in safety, freedom of movement, and training within the institution; and that petitioners infringed these rights by failing to provide constitutionally required conditions of confinement").

[219] *Lewis*, 523 U.S. at 854 (emphasis added).

[220] *See, e.g.*, *Demarco*, 897 F. Supp. at 699. Plaintiff argued that the act of confinement was intentional because "it was defendants' decision to act on their belief that plaintiff was dangerous, rather than the belief itself, that deprived him of his liberty." *Id.* The defendant did not dispute that "every involuntary confinement under the mental hygiene statute is a deliberate act." *Id.* The court agreed that "[t]he alleged deprivation of plaintiff's liberty in the case at bar was the result of a[n] . . . intentional act of confinement." *Id.* at 700. *See also* Plain v. Flicker, 645 F. Supp. 898, 904 n.4 (D.N.J. 1986) ("Since the examiner is the initial decisionmaker it raises the question whether a psychiatrist might have an incentive to commit for the week prior to the judicial hearing. This 'puts the psychiatrist in the self-aggrandizing position of being able to recruit one's own involuntary clients.' ").

[221] *See Jones*, 463 U.S. at 379 (emphasizing that "strong institutional biases lead . . . [psychiatrists] to err when they attempt to determine an individual's dangerousness, especially when the consequence of a finding of dangerousness is that an obviously mentally ill patient will remain within their control"); *see also James*, 1998 WL 664315, at *2 (concerning an allegation that some civil commitments take place to satisfy doctors' "sadistic desires . . . to make an example to others"); *see also* Brooks, *supra* note 6, at 265-66 (discussing numerous reasons that lie behind psychiatrists' intent to commit, including psychiatrists' lack of ability to properly assess for dangerousness that leads them to err on the side of caution and over-commit; psychiatrists' strong support of providing institutionalized treatment regardless of the dangerousness status of an individual; psychiatrists' belief that the former "need for treatment" requirement is the proper standard; as well as psychiatrists' fear of liability for releasing an individual, who is, in fact, dangerous into society).

The second reason federal courts should incorporate *O'Connor*'s dangerousness requirement into their existing legal standards is because the adoption of the presently utilized standards marked the establishment of another pro-psychiatrist era in the law. Prior to *Rodriguez*, the Second Circuit inquired as to "whether it was objectively reasonable for the defendants to believe, at the time they examined [the mentally ill patient] and in light of the information that they possessed, that [the patient] was dangerous."[222] After *Rodriguez*, the issue became whether the decision to commit was made on the basis of "substantive and procedural criteria that are not substantially below the standards generally accepted in the medical community" or, in other words, whether the decision to commit was grossly negligent.[223]

Rodriguez did not merely change the legal standard; it partially contradicted *O'Connor*. The Court in *O'Connor* would support the proposition that it is vital for psychiatrists to "make not just an assessment, but the correct assessment"[224] and any "state official who intentionally confines a person who is a danger neither to himself nor others would be liable for damages."[225] However, the Second Circuit disagreed.[226] It declared in *Rodriguez* that "due process does not require a guarantee that a physician's assessment of the likelihood of serious harm be correct"[227] and it does not expect committing physicians to be "omniscient" in their decisions.[228] All due process requires is that the decision be "made in accordance with a standard that promises some reasonable degree of accuracy."[229] While the court recognized that "[e]rroneous commitments . . . implicate the individual's interest in liberty,"[230] it held that so long as other psychiatrists would make the same mistaken conclusion about one's dangerousness, the state actors would not be liable for wrongful civil commitment.[231] This holding contradicts *Jones*, where the Supreme Court provided that "the Government has a strong interest in accu-

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222 Glass v. Mayas, 984 F.2d 55, 57 (2d Cir. 1993).
223 *Rodriguez*, 72 F.3d at 1063.
224 *Demarco*, 897 F. Supp. at 702.
225 *Id.* at 700.
226 *Rodriguez*, 72 F.3d at 1062.
227 *Id.*
228 *Id.* at 1063.
229 *Id.* at 1062.
230 *Id.* at 1061-62 (quoting Goetz v. Crosson, 967 F.2d 29, 33 (2d Cir. 1992)).
231 *Rodriguez*, 72 F.3d at 1063, 1065.

rate, efficient commitment decisions."[232] In allowing committing psychiatrists to make incorrect conclusions, so long as these determinations are "not substantially below the standards generally accepted in the medical community,"[233] the Second Circuit would find no substantive due process violation in commitments of individuals who pose no danger to themselves or others.[234] Therefore, the Second Circuit's logic violates *O'Connor*, which allows civil confinement only if an individual is both mentally ill and dangerous.[235]

When applying the shocks-the-conscience standard, in theory, the court would impose liability for wrongful civil commitment because *Lewis* clearly declared that "conduct deliberately intended to injure . . . is the sort of official action most likely to rise to the conscience-shocking level."[236] Every commitment is an intentional act.[237] Unfortunately, in practice, the law is not so efficient and the courts that adhere to this standard have yet to find any psychiatrist's decision to commit, even a non-dangerous individual, conscience-shocking.[238] To rectify this injustice, the jurisdictions that adopted the conscience-shocking standard should first decide the factual issue of whether the individual was dangerous at the time of his or her confinement. Only if the factfinder concludes the individual was not, in fact, dangerous, should the court proceed to the issue of whether the psychiatrist's decision to commit the non-dangerous individual was conscience-shocking. Thus, the incorporation of *O'Connor*'s dangerousness requirement would balance the constitutional protections afforded to the mentally ill and protections afforded to state psychiatrists under the rigid shocks-the-conscience standard.

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[232] *Jones*, 463 U.S. at 377.

[233] *Rodriguez*, 72 F.3d at 1063.

[234] *Id.*

[235] *O'Connor*, 422 U.S. at 576.

[236] *Lewis*, 523 U.S. 834.

[237] *See Demarco*, 897 F. Supp. at 699 ("[T]he intentional act of keeping plaintiff in administrative custody provided sufficient state of mind to state a § 1983 action, regardless whether the failure to provide due process was without fault.") (citing Sourbeer v. Robinson, 791 F.2d 1094, 1105 (3d Cir. 1986)).

[238] *See, e.g.*, *Benn*, 371 F.3d at 174; *Obado*, 524 F. App'x at 815; *James*, 1998 WL 664315, at *7.

IV. CONCLUSION

Civil commitment exists to provide a high level of supervised psychiatric care for individuals who are so severely affected by mental illness that community-based services can no longer support and maintain their psychiatric stability. When such instability causes erratic behaviors that put the mentally ill or third parties in danger, civil commitment is an appropriate remedy.[239] At first glance, it may sound like a straightforward concept. However, it is not.

History of civil commitments can help in understanding the issue. From the commencement of civil commitment practice until the mid-twentieth century, psychiatrists had the sole extensive and unrestricted power to determine an individual's "need for treatment."[240] Those deemed to be in need of treatment were civilly confined, often for many years.[241] To determine whether or not one was in need of treatment, psychiatrists relied on their clinical judgments.[242] Lack of any legal requirement to support such clinical judgments often led to abuses of power.[243] An era of new research in the field of psychiatry, development of new anti-psychotic medications, and a rebirth of the civil rights movement revealed concerns of abuse and arbitrariness that, at times, stood behind psychiatrists' clinical judgments.[244]

In 1975, the Supreme Court acknowledged these concerns and proclaimed that only those mentally ill individuals who pose a danger to self or others can be civilly committed.[245] The foundational intention behind the dual requirement was to restrict the power of psychiatrists to confine by providing more objective criteria.[246] The courts were to inquire into the soundness of psychiatrists' determinations and to make the final decision.[247] These safeguards were placed to protect constitutional rights of the mentally ill. However, soon it be-

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239 *O'Connor*, 422 U.S. at 575.
240 *See* Appelbaum, *supra* note 8 and accompanying text.
241 *See supra* note 10 and accompanying text.
242 *See supra* note 8 and accompanying text.
243 *See supra* note 10 and accompanying text.
244 *See supra* note 27 and accompanying text.
245 *O'Connor*, 422 U.S. at 575.
246 *See* Brooks, *supra* note 6, at 262-63.
247 *See* Brooks, *supra* note 6, at 263.

came evident that the dangerousness standard was not without its limitations.

For example, while there is no doubt that psychiatrists can diagnose mental illness within a reasonable degree of medical certainty, it soon became clear that the same cannot be said for their ability to predict dangerousness.[248] Studies revealed that for several reasons, psychiatrists extensively overpredict when determining whether a person is dangerous.[249] First, the concept of danger is vague.[250] Jurisdictions across the country fail to provide precise definitions that would incorporate all aspects of danger and disagree about what it entails.[251] This failure allows psychiatrists to craft their own subjective understanding of what dangerousness incorporates and fit the reported symptoms into those personalized definitions.[252] Second, mental health professionals often rely on their clinical judgments rather than on actuarial methods of prediction when assessing dangerousness.[253] In practice, this means that judges have no way of testing psychiatrists' assessment conclusions, because these conclusions are based solely on psychiatrists' professional experience. Third, regardless of the courts' awareness about psychiatrists' lack of proficiency in detecting dangerousness, courts still heavily defer to psychiatrists' expert testimony during commitment hearings.[254] Fourth, mental health professionals fear liability if they fail to confine a dangerous mentally ill person.[255] On the other hand, they rarely face liability if they confine a non-dangerous mentally ill person.[256] The rare challenges to wrongful civil confinements face very pro-psychiatrist legal

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[248] *See supra* note 116 and accompanying text.

[249] *Id.*

[250] *See supra* note 98 and accompanying text.

[251] *See, e.g.*, *Stevens*, 761 P.2d at 772-73 nn.4-7; *see also supra* note 119.

[252] *See supra* note 118 and accompanying text.

[253] *See* Brooks, *supra* note 6, at 272:

> [O]nly a minority, and maybe a small minority, of mental health professionals employ structured risk assessment techniques . . . despite advances in knowledge about the risk of violence by people with mental illness, there have been virtually no . . . efforts to incorporate the information into a useful, empirically-based framework for clinical assessment.

Id.

[254] *See supra* note 127 and accompanying text.

[255] *See supra* note 133 and accompanying text.

[256] *See supra* note 135 and accompanying text.

standards that govern imposition of liability.[257]

Currently, the circuits are split on the appropriate standard to determine whether liability should be imposed on a state psychiatrist for a wrongful civil commitment. The Second and Ninth Circuits only impose liability if the decision to confine a mentally ill person, regardless of whether he or she was in fact dangerous at the time of civil commitment, was based on judgment that is "substantially below the standards generally accepted in the medical community."[258] There is no requirement for psychiatrists to be correct in their judgments at all.[259] Therefore, so long as other psychiatrists would also wrongfully confine, liability does not follow. The Third and Tenth Circuits impose liability on psychiatrists only if the decision to commit a mentally ill individual, dangerous or not, "shocks the conscience."[260]

Neither one of the adopted standards takes into account the constitutional protections imposed by the Supreme Court in *O'Connor*.[261] Under *O'Connor*, the only way a mentally ill person can be constitutionally deprived of his or her liberty is if he or she poses a threat to self or others.[262] Thus, courts fail to recognize that as soon as a psychiatrist makes an erroneous decision to confine a non-dangerous mentally ill person, the wrongfully civilly confined individual is being deprived of his or her Fourteenth Amendment right to liberty, and liability should follow.

To reconcile the discrepancy in protections afforded by the courts to mental health professionals and the mentally ill, the courts should incorporate *O'Connor*'s dangerousness requirement into their current standards. To avoid further manipulations of the concept of dangerousness, states and courts should define what this concept involves. Psychiatrists should be required to utilize reliable methods of dangerousness prediction. Courts should consider utilizing independent expert testimony at trial to test committing psychiatrists' conclusions. Lastly, legal professionals who represent mentally ill individuals should demonstrate the utmost level of advocacy during

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[257] *See supra* note 16 and accompanying text.

[258] *Rodriguez*, 72 F.3d at 1063.

[259] *Id.* at 1062.

[260] *See Benn*, 371 F.3d at 174; *Obado*, 524 F. App'x at 815; *James*, 1998 WL 664315, at *7.

[261] *See Benn*, 371 F.3d 165; *Bolmer*, 594 F.3d 134; *Jensen*, 312 F.3d 1145; *Rodriguez*, 72 F.3d 1051; *Obado*, 524 F. App'x 812; *James*, 1998 WL 664315, at *1.

[262] *O'Connor*, 422 U.S. at 575.

commitment hearings to prevent wrongful civil confinements. They should remember that strong legal representation might be the only hope that people affected by mental illness have. By securing all these safeguards, the law will be able to provide mentally ill individuals with the level of protection the Fourteenth Amendment requires.