Approved 1/29/85
Date

MINUTES OF THE HOUSE COMMITTEE ON JUDICIARY.

The meeting was called to order by Representative Joe Knopp at
Chairperson

3:30 ~~a.m.~~/p.m. on January 23, 1985 in room 526-S of the Capitol.

All members were present except:
Representative Wagnon was excused.

Committee staff present:
Jerry Donaldson, Legislative Research Department
Mike Heim, Legislative Research Department
Mary Ann Torrence, Revisor of Statutes' Office
Becca Conrad, Secretary

Conferees appearing before the committee:
Dr. Robert Harder, Secretary of Department of Social and Rehabilitation Services
Bill Rein, Attorney, Department of Social and Rehabilitation Services

HB 2050 - An act concerning care and treatment of mentally ill persons.

Dr. Harder presented an overview of this bill which is covered in Attachment No. 1 and Bill Rein, who is an attorney at Larned Hospital, answered questions. Dr. Harder stated that a critical and important issue of this legislation is a redefinition of "mentally ill".

The Chairman asked what the basis was behind the change from two to five days from the issuance of an ex parte order of protective custody. Mr. Rein stated that he felt that two days was not enough time to properly prepare for a hearing.

Representative Walker asked about the status of a patient during this five day period as far as the administration of medication. Mr. Rein stated that a patient can and does have medication within that five day period even if it is against their will.

The Chairman inquired as to a probable cause hearing. Mr. Rein stated that the petitioner, who is trying to institutionalize a person, must come forward with enough evidence to convince the court that the person is probably mentally ill as defined by law. The Chairman asked what would happen to the person between the filing of a petition and the proposed five day period when the hearing is scheduled. Mr. Rein stated that the person would normally go to the hospital on an order of protective custody which is issued ex parte without any hearing. Mr. Rein then stated that the patient cannot refuse treatment within that five day time. Mr. Rein explained that an evaluation, which is performed within that five day period, involves an interview with a nursing service representative, a social worker, a physician, and a psychiatrist. The Chairman asked if the evaluation was in any way intrusive on the patient. Mr. Rein said he felt it was not intrusive in the way of being painful. Mr. Rein stated the section that said the patient should have the right to refuse the evaluation before the probable cause hearing should be changed. He felt the hospital has to start an evaluation within that five day period. Mr. Rein said that at the probable cause hearing the applicant must present testimony sufficient to convince the judge that probably the person is mentally ill as defined by law. At that time the court enters a regular order of protective custody that will be good until the conclusion of the regular preliminary hearing of not later than 14 days.

The Vice Chairman appointed a subcommittee made up of Representatives Bideau, O'Neal and Whiteman, chairman, to meet with the Revisor and Mr. Rein to draft language for new Section 18. He stated the committee should meet between today and January 31st.

The Vice Chairman also announced that the committee would take this proposal under consideration again on Thursday, January 31, 1985.

The meeting was adjourned at 5:02 p.m.

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Statement Regarding H.B./S.B. 2050

1. Title - This is a comprehensive bill concerning the act for obtaining treatment of mentally ill persons, K.S.A. 59-2901, et.seq.

2. Purpose - Laws pertaining to the civil commitment of mentally ill persons were last addressed on a comprehensive basis in 1976. Like many other state legislatures in the early seventies, the Kansas legislature enacted a number of specific requirements for providers of mental health services to follow. The result of these changes was to reduce the amount of discretion available to mental health professionals in providing treatment.

   The intent of this bill is to restore a greater degree of discretion in those professionals who are expected to provide treatment, to simplify some current procedures, and to clarify issues of national importance.

3. Background - Many issues of mental health law have been addressed in recent years by state and federal courts throughout the nation. Among the most notable are the right of an involuntary patient to refuse treatment (especially psychotropic medication), civil liability of treatment professionals for the assaultive actions of their patients following discharge, proper content of involuntary commitment hearings, and the amount of psychiatric discretion which should be available for professionals in carrying out treatment. An additional issue which the courts have addressed concerns the definition of those persons who are subject to involuntary commitment.

   The guiding philosophy of this legislation is that persons subject to commitment must suffer from a "severe mental disorder," which does not include a primary diagnosis of antisocial personality, and which renders the person "likely to cause harm to himself or to suffer substantial mental or physical deterioration or to cause harm to others" if treatment is not provided. It is also the philosophy of this Act that state hospital staff should be granted the authority to divert patients to community alternatives at any point in the commitment proceedings. Due to the enormous amount of time that is required by mental health professionals in preparing for hearings, this legislation will provide for judicial involvement only when hospital staff believe that inpatient treatment beyond 21 days is necessary. Time periods within the commitment process would be extended so as to allow a greater amount of time to conduct mental examinations, background investigations, and community assessments of alternative treatment possibilities. Staff should also be protected from liability for admission and discharge decisions in carrying out public policy initiatives toward less restrictive principles of treatment, in the absence of gross and wanton conduct.

4. Effect of Passage - Passage of this bill would provide a proper balance between a patient's right of autonomy, without unduly restricting professional judgment. This bill would also foster greater cooperation between community mental health centers, state hospitals, and district courts.

5. SRS Recommendation - The Department of Social and Rehabilitation Services supports this bill because it properly balances patient autonomy with the practical needs of mental health professionals in providing treatment.

Robert C. Harder
Secretary
Social and Rehabilitation Services
296-3271

January 23, 1985

Attachment No. 1
House Judiciary
January 23, 1985

STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
Statement Regarding H.B./S.B._____

TESTIMONY

The summary of the comprehensive civil commitment bill accompanies this section on proposed testimony and presents an overview of the purpose and background for this legislation.

There are a number of specific problems which have gained the attention of courts and legislatures throughout the nation since passage of the last comprehensive commitment act in Kansas of 1976. Those issues include the definition of those individuals who should be subject to involuntary commitment, the rules of evidence which should apply at commitment hearings, the rights of patients to remain silent in court ordered examinations, the timing and content of periodic judicial review for those patients who have been committed, the advisability of involuntary outpatient commitment, the rights of involuntary patients to refuse treatment (especially psychotropic medication), and the civil liability of mental health professionals for assaultive acts of their patients following discharge. Passage of this bill would assure that Kansas has addressed each of these major policy issues for the guidance and protection of both patients and mental health professionals.

The guiding philosophy of this bill is to recognize that mental health law is a rapidly developing area which must be periodically reassessed in order to assure that major policy issues are resolved through appropriate legislation. Recent decisions by the U.S. Supreme Court in the area of mental health law have stated that courts must give due regard to the exercise of professional judgment in the rendering of psychiatric treatment. One such case is that of Youngberg v. Romeo, 102 S.Ct. 2452 (1982). In that case, the Supreme Court made a number of statements which reassert the importance of professional judgment in making proper treatment decisions:

> "...the constitution only requires that the courts make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made."
>
> "in determining what is 'reasonable'--in this and in any case presenting a claim for training by a state--we emphasize that courts must show deference to the judgment exercised by a qualified professional."
>
> "in determining whether the state has met its obligations in these respects, decisions made by the appropriate professional are entitled to a presumption of correctness."

It is no longer a serious question for mental health professionals that patients are entitled to due process of law prior to involuntary civil commitment. As a procedural safeguard, due process demands that before a person can be hospitalized without consent, such person must receive notice of the pending legal action, a reasonable opportunity to prepare for hearing, and a hearing before an impartial finder of fact. However, the questions of who may be subjected to involuntary commitment, and whether the committed person retains any rights to refuse treatment once committed, remain subjects of current controversy. In addition, the proper balance between maximum personal autonomy of the patient and the right of professionals to provide the treatment which the court has ordered also requires periodic reassessment.

Passage of the comprehensive commitment bill would provide a reassessment of issues which have either presented themselves since 1976, or have undergone some legal maturity since that time. The guiding philosophy of this legislation is that persons subject to commitment must suffer from a "severe mental disorder," other than a primary diagnosis of antisocial personality, which renders the person "likely to cause harm to himself or to suffer substantial mental or physical deterioration or to cause harm to others" if treatment is not provided. In order to avoid some of the costly administrative and judicial procedures mandated in some jurisdictions (Massachusetts) regarding the rights of involuntary patients to refuse treatment, this legislation would also require a committing court in Kansas to reach both the issues of dangerousness and ability to make informed consent concerning need for treatment at commitment hearings. To provide ample due process on behalf of a proposed patient which finally culminates in an order of treatment, without allowing professionals to provide those standard psychiatric modalities which appear to be needed, would be an injustice to everyone involved in the proceedings and a enormous waste of human resources. Therefore, this act provides that the court must determine the issue of ability to give informed consent prior to entering any order of treatment, but that once treatment is ordered, the mental health professionals called upon to provide the same could do so regardless of the patient's treatment refusals.

It is also the philosophy of this act that state hospital staff, and other treatment facilities if operating pursuant to the Act, should be granted the authority to divert patients to community alternatives at any point in the commitment proceedings. K.S.A. 59-2924(c)-Section 17, Pg.29. Due to the enormous amount of time that is currently being required of mental health professionals to prepare for and provide testimony in hearings under the Act, courts should only be involved when hospital staff believe that inpatient treatment is needed beyond 21 days. If hospital staff are able to obtain treatment on an outpatient basis, or if the patient is willing to accept voluntary treatment on a rational basis, the additional necessity of adversary hearings might be

avoided. It is only in those cases where long term treatment (beyond 21 days) is recommended that courts should resolve the basic social issues involved in balancing the patient's right to personal autonomy against the right of society to protect itself and treat serious mental disorders. As a result of this philosophy, time periods within the commitment process should be extended to allow a greater amount of time to conduct mental evaluations, background investigations, and community assessments of alternative treatment possibilities. Staff should also be protected from liability for admission and discharge decisions in carrying out public policy initiatives toward least restrictive principles of treatment, in the absence of gross and wanton negligence. Finally, in those cases where commitment hearings are necessary, the court should admit all relevant evidence having probative value of a kind and nature which is usually accepted as necessary for proper clinical judgment.

A summary of the major changes which passage of this bill would bring to the civil commitment process in Kansas follows:

The definition of mentally ill person who is subject to involuntary commitment would include, in addition to those persons who are likely to cause harm to self or others, those individuals who are "likely...to suffer substantial mental or physical deterioration." The latter are defined as those persons who "will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress causing a substantial deterioration of his ability to function on his own." This may be a controversial portion of the Act, but it is not a return to commitment upon a finding of "need for treatment" only. This language was taken substantially from the Harvard Journal on Legislation: A Model State Law on Civil Commitment of the Mentally Ill by Clifford D. Stromgberg and Alan A. Stone, Vol. 20, No.2 (Summer 1983). Commentary on this definition is contained on pages 303 to 305 of that publication. Suffice it to say that this definition is not intended to allow the commitment of persons who simply choose a life style that may offend the majority. Rather, it is intended to allow the commitment of those persons whose severe and abnormal condition causes a substantial deterioration of ability to function independently. At footnote 81 of the model commitment Act the following point is made that seems relevant to possible opposition:

This provision should not be as constitutionally vulnerable as the old "in need of treatment" statutes. Under the Model Law, commitment requires a severe mental disorder, treatability, lack of capacity, and clear and convincing proof of likely harm. It provides for a definite term of commitment and the right to treatment. The Supreme Court in O'Connor v. Donaldson, 422 U.S.563 (1975), did not discuss the constitutionality of such a set of commitment criteria, but decisions since then indicate that this provision should be upheld.

See, e.g., Doe v. Gallinot, 486 F.Supp. 983 (CD Cal. 1979); Reynolds v. Sheldon, 404 F.Supp. 1004 (N.D. Tex. 1975); Colorado v. Taylor, 618 P.2d 1127 (Colo. 1980).

The definition would also include a finding by the court that the proposed patient "lacks capacity to make an informed decision concerning treatment." This would assure that those patients who were committed could be treated with standard psychiatric interventions regardless of the patient's treatment refusals. It would be an enormous waste of resources to have a commitment hearing without reaching the issues which would allow treatment professionals to provide that treatment which seems reasonably necessary to restore the patient to independent living if at all possible.

K.S.A. 59-2907 is amended to comply with the changes enacted by the 1984 legislature in the Guardianship Act, specifically K.S.A. 59-3018(g)(1). Pursuant to that amendment, guardians can no longer sign their wards into facilities under the treatment act without a 59-2917 hearing. However, relevant provisions of the Civil Commitment Act were not changed in order to conform to the new guardianship provisions. Another amendment to 59-2907 merely makes it clear that an involuntary application can be filed against a voluntary patient "who is refusing reasonable treatment efforts," but who also refuses to request discharge from the facility. It is clear that when a voluntary patient refuses reasonable treatment offered by the hospital, the patient can be discharged. However, in those cases where the patient would clearly present a danger to self or others if discharged, the treatment facility is left in the impossible position of maintaining the individual in the hospital without being able to treat. This provision will not effect a great number of patients, but will clearly reflect a proper balance between the rights of voluntary patients to withhold consent to treatment and the right of the facility to discharge those patients who are not in good faith wanting treatment.

K.S.A. 59-2912 is amended in a way that should simplify the manner in which district courts may issue orders of protective custody. Under the new Act, the court could issue an ex parte order of protective custody upon the application of any person, including a law enforcement officer, upon the filing of an affidavit by the applicant. Since this order would be issued without a hearing, it would expire not later than 5:00 o'clock p.m. of the 5th full day that the district court is open for the transaction of business. Further, the district court would be prohibited from issuing successive orders under this subsection. It should be noted that this section deals with orders of protective custody and not emergency admission. Therefore, there seems to be no reason to distinguish between applications which are filed by law enforcement officers and applications which are filed by any other per-

sons. Since the regular application for determination of mental illness must also be filed before an order of protective custody can be issued, both law enforcement officers and other persons would need a physician's statement or a verified statement that the proposed patient had refused medical examination before seeking an order of protective custody.

59-2912 would allow the court to issue an order of protective custody following a probable cause hearing to be held not later than 5:00 o'clock p.m. of the 5th full day that the court is open for the transaction of business pursuant to subsection (b). Currently, the law requires a probable cause hearing within 48 hours of the issuance of an ex parte order of protective custody. It is the philosophy of this Act that 48 hours does not allow sufficient time for hearing preparation, and that a reasonable extension is constitutional. Moreover, since the Act allows the treatment facility to divert patients at any time without further order of the court pursuant to K.S.A. 59-2924(c), the extension of time would also allow the hospital to obtain alternative treatment, thus avoiding the necessity of even an adversary probable cause hearing.

This section also expands the rules governing evidentiary matters at probable cause hearings. It would make it clear that "hearsay evidence may be received, and experts and other witnesses may testify to any relevant and probative facts at the discretion of the court." There are real differences between criminal trials and civil commitment hearings which have not always been recognized by the courts. In criminal trials, the only relevant evidence is what happened on the day that the alleged criminal act occurred. However, commitment hearings must answer the question of whether or not the patient is likely to cause harm to self or others in the future. As a result, the patient's previous behavior and history of psychiatric treatment are extremely important, and not simply what happened last Thursday afternoon that resulted in injury to the patient or another.

K.S.A. 59-2914 would change the minimum and maximum time periods for regular commitment hearings from seven and 14 days to 14 and 21 days respectively. It would also provide for a mandatory order of investigation prior to the hearing as well. Finally, it would allow the court to consolidate commitment and guardianship hearings in an effort to conserve the time of all concerned.

K.S.A. 59-2914a would provide that an order for mental evaluation could be entered without the necessity of a probable cause hearing. If hospital staff are to have the right of diversion, they should be able to begin the evaluation process as soon as the patient is admitted. This

should be true even under current law since the hospital must evaluate the patient to provide protective custody. The hospital must be allowed to evaluate a patient immediately upon admission to at least ascertain what types of protective measures against self abuse or dangerousness to others need to be taken. A patient should not have the right to any type of hearing before the hospital can evaluate his or her needs. In addition, the issue of a patient's "right to remain silent" at a psychiatric examination or hearing under the Act is rejected, "provided that no patient shall be held civilly or criminally liable for not speaking or testifying."

K.S.A. 59-2916(a) has been a point of confusion for many courts. It relates to the issue of whether or not patients may be administered medication prior to and during commitment hearings. The Act has always said that patients need only be removed from medication if the physician believes that such medication "adversely effects such patients judgment or hampers such patient in preparing for or participating in the hearing." Some attorneys have argued that this means patients must not receive any psychotropic medication, which is not appropriate for either the patient's treatment needs or ability to take a meaningful part in the hearing. In most cases, psychotropic medication greatly assists the patient in taking a meaningful part in his hearing. The amendment proposed would indicate in clearer terms that patients need not be removed from medication unless it will have an adverse impact on hearing competency.

New Section 14 would allow the court, following a hearing for regular commitment, to enter an order for outpatient treatment. Currently, some courts have fashioned outpatient treatment orders, while others have felt that the present act does not allow for same. The proposed outpatient treatment provision does not effect either the burden of proof or the definition of mentally ill person, but only indicates that the court has an additional option in ordering the place of treatment. It attempts to deal with the original order for outpatient treatment, terms of the treatment, and revocation in a method that will require the least possible amount of actual court involvement.

K.S.A. 59-2922 is drafted to simplify the matter of venue changes from one court to another. There have been times under the current law when a treatment facility is caught between two courts, neither of whom is wishing to exercise jurisdiction over the patient. On occasion, venue of a case is changed from the orginating court to another court, and therefore the originating court is not willing to issue further orders. In contacting the receiving court, however, it does not feel that venue was properly changed, or does not wish to accept the change of venue. Change of venue should be simplified to the greatest possible extent to avoid

leaving patients and treatment facilities in a position where no court is desiring to exercise jurisdiction. The proposed amendments would indicate that venue of an action could be changed to the court where the treatment facility is located at any time, but could be changed to any other court only if the court finds that the patient cannot obtain a fair hearing.

K.S.A. 59-2924 simplifys the matter of administrative transfers from a state psychiatric hospital to other state institutions. Currently, there are a number of laws attempting to regulate administrative transfers with conflicting provisions. This provision should clarify the matter for patients and hospital staff alike. Subsection (c) of this provision also requires the head of the treatment facility to investigate all applications for involuntary admission with the intent of obtaining a diversion without need of further judicial action, whenever possible.

K.S.A. 59-2926 would authorize a treatment facility to order a law enforcement officer to take an involuntary patient into custody when the patient was absent without official leave. This authorization could be done either orally or in writing, but oral authorization would have to be confirmed in writing as soon as possible.

New Section 16 would simplify the matter of periodic judicial review. The current laws indicate that patients have the right to a review proceeding every 90 days, as well as the right to petition for their discharge every 6 months. Courts differ in their interpretation of whether or not both of these authorize an adversary hearing procedure. In order to avoid confusion, it seems most reasonable to consolidate these procedures into one procedure which is clearly defined by statute. The proposed provisions would allow a patient to request a hearing every 90 days during the first 6 months of treatment, and every 180 days thereafter to determine whether or not such patient continues by clear and convincing evidence to be a mentally ill person. These hearings would be conducted in an adversary manner, and the attorney for the proposed patient would be required by law to consult with the patient concerning the patient's desires for a hearing. The requirement that the hospital initiate a report to the court every 90 or 180 days would continue, so that the patient would not have to be responsible for deciding when a request for hearing should be filed.

K.S.A. 59-2928 concerning seclusion and restraint would contain an amendment allowing staff at State Security Hospital to confine patients in their rooms when that was deemed necessary for security or proper institutional managment. Due to the fact that many of the patients which state security hosptial receives have been transferred directly

from county jails or the Secretary of Corrections, as well as the fact that they are all under orders for criminal commitment, State Security Hospital should be allowed some additional authority in maintaining appropriate security. If patients were to be confined to seclusion rooms, regular procedures for obtaining seclusion orders from physicians would have to be followed.

K.S.A. 59-2929, the patients rights statute, would be amended very little. However, "the right to mail any correspondence which does not violate postal regulations" would be stricken in favor of that section which indicates that patients have the right to communicate by letter, both to mail and receive unopened correspondence, except when the head of the treatment facility should enter restrictions following the procedures set forth in subsection (b). These two provisions of the current act have been confusing to interpret, with the effect that patients have always been allowed the right to mail any correspondence to any individual, a right which seems to allow restriction by subsection (2). On occasion, patients have mailed extremely disturbing documents to people in the community (mutilated pages from magizines), or have ordered a large amount of merchandise for which they could not pay. This has meant that patients have sometimes ordered several pairs of boots which had to be returned at hospital expense upon arrival due to the fact that the patient could not pay for same. Moreover, patients could turn around and order the boots again because of "the right to mail any correspondence which did not violate postal regulations." This change is not intended to return to the days of covert censorship, and if a patients right to mail or receive unopened correspondence was ever restricted, those restrictions would have to be made a part of the medical record and provided to the patient and the patient's attorney.

K.S.A. 59-2931 would be amended to clearly state that those minors, at least 14 years of age, who have requested voluntary admission should also have the capacity to consent to the release of their treatment records. In addition, this provision would allow treatment facilities to share medical records with Kansas Mental Health Centers and the Department of Corrections for purposes of aiding in the continuity of treatment following discharge. Since the state is attempting to move toward an integrated mental health system between state hospitals and mental health centers, these provisions would be extremely helpful.

K.S.A. 59-2932 would grant immunity from civil liability to state psychiatric hospitals and their employees concerning decisions refusing admission of a person to, or discharging or conditionally releasing a patient from, a treatment facility, absent gross or wanton negligence. It is the philosophy of this Act that society has much to gain from

returning patients to the community as soon as reasonably possible, from giving patients second chances to become independent and productive members of society, and from seeing that patients are treated with the greatest amount of personal autonomy possible. This is a controversial issue throughout the nation, with a great deal of complexity. Although Kansas has recognized wrongful discharge as a cause of action grounded in medical malpractice by virtue of Durflinger v. Artiles, 234 Kan. 484 (1983), there is a growing body of case law that clearly distinguishes ordinary medical decisions from psychiatric discharge decisions. Two recent cases, Brady v. Hopper, 570 F.Supp. 1333 (D.Colo. 1983) and Sherrill v. Wilson, 653 S.W. 2d 661 (Mo.Supp. Ct. 1983), cite the strong legal push on psychiatry during the past decade to discharge patients as soon as possible and the difficulty of predicting dangerous behavior. This issue may best be addressed by reviewing the attached article "Having It Both Ways: Surveying the Area Between Least Restrictive Alternative and Wrongful Discharge," which attempts to deal with the complexity of this issue. It does seem reasonable that if professionals are expected to restore patients to the community as soon as possible, there should not be any unnecessary restraint on their willingness to grant passes and discharges. Those decisions are not unaffected by state policy, and therefore are not purely medical decisions. Society as a whole must bear some of the risk inherent in the fact that future dangerous behavior of patients cannot be easily predicted by either courts, parol boards, or psychiatrists. Legislative protection for decisions that are not gross and wanton should be authorized.

The Department of Social and Rehabilitation Services is in support of this legislation because it will simplify and clarify procedures to be followed by Kansas mental health professionals in addressing those developing issues relevant to the field of mental health law. The bill will also encourage integration of community mental health centers with state psychiatric hospitals and preserve precious resources of treatment professionals and judicial officials.

HARVARD JOURNAL

on

LEGISLATION

Understanding requires a fundamental appreciation of those aspects of the proposed treatment that a reasonable person would find significant in decisionmaking. A patient need not understand every technical feature of a proposed therapy.

Even if an individual can understand the nature and effects of treatment, he lacks capacity if, due to his mental disorder or condition, he cannot engage in any rational decisionmaking process because, for example, he is unable to weigh the risks and benefits of the proposed therapy. The definition requires inability to engage in any rational process, not simply the one that the physician or court would employ. Rational modes of thinking may be unusual, eccentric, or even inconsistently related to reality. A patient's phobia, for example, might distort his apprehension or appreciation of particular facts without impairing his ability to reason concerning other facts or decisions.[68] Another patient's delusions, however, might broadly impair his ability to reason. An individual afflicted with a severe mental disorder may be unable to pay attention to and assimilate information, or his disorganized thoughts may preclude him from engaging in anything resembling a rational process.[69] Only this type of patient lacks capacity under the Model Law.[70]

> **"*likely to cause harm to himself or to suffer substantial mental or physical deterioration*" means that, as evidenced by recent behavior, the person (1) is likely in the near future to inflict substantial physical injury upon himself, or (2) is substantially unable to provide for some of his basic needs such as food, clothing, shelter, health, or safety, or (3) will if not treated suffer or continue to suffer severe and abnormal mental, emo-**

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[68] *See* Appelbaum & Roth, *supra* note 63. A patient's ability to reason may be severely impaired by a variety of other conditions such as anxiety, panic, depression, euphoria, anger, or obsessive preoccupation.

[69] Several empirical studies conclude that a large percentage of current mental patients do lack capacity. *See* Appelbaum, Mirkin & Bateman, *supra* note 53; Munetz, Roth & Cornes, *supra* note 54; Olin & Olin, *Informed Consent in Voluntary Mental Hospital Admissions*, 132 AM. J. PSYCHIATRY 938 (1975); Palmer & Wohl, *Voluntary-Admission Forms: Does the Patient Know What He's Signing?*, 23 HOSP. & COMMUNITY PSYCHIATRY 250 (1972); Pryce, *Clinical Research upon Mentally Ill Subjects Who Cannot Give Informed Consent*, 133 BRIT. J. PSYCHIATRY 366 (1978); Soskis, *supra* note 58.

[70] The Model Law's definition is far more specific than the definition of competence as "capable" of making a responsible treatment decision that was struck down as unconstitutionally vague in Colyar v. Third Judicial Dist. Court, 469 F. Supp. 424 (D. Utah 1979). *Compare In re* B., 156 N.J. Super. 231, 234, 383 A.2d 760, 762 (1977) ("The court finds the patient's refusal to take Prolixin is not, however, based entirely on rational considerations, but reflects delusional thinking."), *with* Lane v. Candura, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978) (patient's irrational refusal to consider medical treatment does not establish incompetency), *and In re* Quackenbush, 156 N.J. Super. 282, 287, 383 A.2d 785, 788 (1978).

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291 N.C. 693, 231 S.E.2d

[72] *Cf. In re* Mendoza, 43
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[74] *See, e.g.*, ALA. CODE
INST. CODE §§ 5260, 5300
(same); ILL. REV. STAT. c
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GEN. STAT. § 17-176 (197
(1980) (same); PA. STAT.
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[75] *See, e.g.*, Suzuki v.
Dist. Court, 469 F. Supp.
849 (W. Va. 1980).

[76] *See, e.g.*, ARIZ. REV.

tional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior causing a substantial deterioration of his previous ability to function on his own.

COMMENTARY: In subsection 6.C, the Model Law authorizes some involuntary commitments based on the parens patriae doctrine, that is, when necessary for the patient's own good. Such commitments are justified only if it can be predicted that the person will soon harm himself, and that this likelihood is due to his severe mental disorder. This prediction of harm cannot be based solely on descriptions of the person's mental processes; it must be grounded in the patient's "recent behavior."[71] The harm must be more than possible; it must be probable or "likely."

The first of the three possible grounds for parens patriae commitment is that the person "is likely in the near future to inflict substantial physical injury upon himself." Ordinarily, this will mean a recent, credible threat of or attempt at self-mutilation or suicide, accompanied by a mental state indicating a likely recurrence.[72] The harm must be predicted to occur "in the near future"; this accords with the trend in state statutes[73] and court decisions[74] towards defining the time period more explicitly.

The second basis for parens patriae commitment is that the person "is substantially unable to provide for some of his basic needs." Many state laws denote such individuals as "gravely disabled."[75] Inability to provide for even one critical need may

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[71]The courts are moving toward the view that commitment is not warranted simply because that person "might be dangerous if this pattern of thinking continued as it seemed to be developing." *In re* Conrad, 34 Or. App. 119, 119–120, 578 P.2d 1, 1–2 (1978); *see also In re* Chapman, 67 Ill. App. 3d 382, 385 N.E.2d 56 (1978); *In re* Hatley, 291 N.C. 693, 231 S.E.2d 633 (1977).

[72]*Cf. In re* Mendoza, 433 A.2d 1069, 1071–72 (D.C. 1981) (likely injury to one's career and reputation held not sufficient to justify confinement); N.C. GEN. STAT. § 122-58.2(1)(a) (1981); PA. STAT. ANN. tit. 50, § 7301 (Purdon 1969 & Supp. 1982–1983).

[73]*See, e.g.*, ALA. CODE § 22-52-1 (1975) ("real and present danger"); CAL. WELF. & INST. CODE §§ 5260, 5300 (West 1969) ("imminent" harm); GA. CODE § 88-501(v) (1982) (same); ILL. REV. STAT. ch. 91 1/2, § 1-119 (1981) ("in the near future"); MICH. COMP. LAWS § 330.1401 (1979) (same); MONT. CODE ANN. § 53-21-102(14) (1981) ("imminent" harm); N.C. GEN. STAT. ch. 122-58.2 (1981) ("within the near future"). *But see* CONN. GEN. STAT. § 17-176 (1975) (no standard for proximity of harm); IDAHO CODE § 66-317 (1980) (same); PA. STAT. ANN. tit. 50, § 7301 (Purdon 1969 & Supp. 1982–1983) ("reasonable probability that death, serious bodily injury, or serious physical debilitation would ensue within 30 days").

[74]*See, e.g.*, Suzuki v. Yuen, 617 F.2d 173 (9th Cir. 1980); Colyar v. Third Judicial Dist. Court, 469 F. Supp. 424 (D. Utah 1979). *But see* Hatcher v. Wachtel, 269 S.E.2d 849 (W. Va. 1980).

[75]*See, e.g.*, ARIZ. REV. STAT. ANN. § 36-540(C) (1974 & Supp. 1981–1982); ARK.

justify commitment on this basis. For example, a severely mentally ill "bag lady" who scrounges sufficient food and clothes for her needs but who sleeps in city alleys and doorways might be committable because she cannot provide for her health or safety.

One serious concern that has arisen over use of such a "gravely disabled" concept is that it should not be used to commit people whose lifestyle simply offends the majority. Some courts have granted "gravely disabled" commitments based on what appears to be (from the limited data in the published opinions) tenuous grounds.[76] Other courts, however, have refused to order such commitments in a surprising number of cases.[77] Under subsection 6.C of the Model Law, a person is, in effect, considered gravely disabled only if his alleged inability to care for himself is due to a "severe mental disorder," rather than a choice of lifestyle or other factors. To be committable on this basis, he must also lack the capacity to make an informed decision concerning treatment. These factors should minimize abuse and make the Model Law constitutionally acceptable.[78]

The third alternative basis for parens patriae commitment is that, due to a "severe mental disorder," the person is likely to "suffer substantial mental or physical deterioration." This provision makes treatment available to a clearly defined group of severely mentally ill persons commonly excluded from the mental health system by current legal standards.[79] It applies only to persons who will suffer "severe and abnormal mental, emo-

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STAT. ANN. § 59-1401(C) (1971 & Supp. 1979); CAL. WELF. & INST. CODE § 5008(h)(1) (West 1969 & Supp. 1982); COLO. REV. STAT. § 27-10(102)(5) (1976); CONN. GEN. STAT. § 17-176 (1975); IDAHO CODE § 66-329(k) (1980); *cf.* NEB. REV. STAT. § 83-1009 (1981).

[76] *See, e.g.*, Walker v. Dancer, 386 So. 2d 475 (Ala. Civ. App. 1980); Estate of Roulet, 23 Cal. 3d 219, 590 P.2d 1, 152 Cal. Rptr. 425 (1979); *In re* Paiz, 43 Colo. App. 352, 603 P.2d 976 (1979); *In re* Evans, 86 Ill. App. 3d 263, 408 N.E.2d 33 (1980); *In re* Janovitz, 82 Ill. App. 3d 916, 403 N.E.2d 583 (1980); *In re* Frick, 49 N.C. App. 273, 271 S.E.2d 84 (1980).

[77] *See, e.g.*, County Attorney v. Kaplan, 124 Ariz. 510, 605 P.2d 912 (1980); *In re* Linderman, 417 N.E.2d 1140 (Ind. 1981); *In re* Field, 120 N.H. 206, 412 A.2d 1032 (1980); Sheffel v. Sulikowski, 62 Ohio St. 2d 128, 403 N.E.2d 993 (1980); State *ex rel.* Pifer v. Pifer, 273 S.E.2d 69 (W. Va. 1980).

[78] In Doe v. Gallinot, 486 F. Supp. 983, 991 (C.D. Cal. 1979), the court conceded that "there could be some difference in interpretation of what constitutes basic need," but held a "gravely disabled" standard not unconstitutionally vague. *See also* Colorado v. Taylor, 618 P.2d 1127 (Colo. 1980). Some courts have read into the "gravely disabled" standard a "lack of capacity" requirement. *See, e.g.*, Walker v. Dancer, 386 So. 2d 475 (Ala. Civ. App. 1980); Northern v. State Dep't of Human Servs., 575 S.W.2d 946 (Tenn. 1978).

[79] *See supra* notes 8–14 and accompanying text.

tional, or physical distress."[80] The usual grief and depression over the death of a loved one clearly would not be "abnormal," and would therefore not justify commitment. Physical distress caused by a mental illness (for example, intractable pain, or delirium tremens (DTs) associated with an alcoholic brain syndrome) could suffice, but other physical distress would not.

Further, the distress must impair the person's reason or behavior so severely as to cause a major decline in his ability to function. This requirement suggests an acute episode or sudden collapse of mental state (decompensation). If a usually withdrawn and solitary person shuns society, it may be less solid evidence of a sudden change in mental condition than if a gregarious, well-adjusted person does so. The Model Law thus avoids judging individual lifestyles, but permits commitment of severely mentally ill individuals who are moving toward sudden collapse.[81]

> **"*likely to cause harm to others*" means that as evidenced by recent behavior causing, attempting, or threatening such harm, a person is likely in the near future to cause physical injury or physical abuse to another person or substantial damage to another person's property.**

COMMENTARY: In subsection 6.C, the Model Law authorizes involuntary commitment for the protection of society. Such police power commitments are predicated on "recent behavior causing, attempting, or threatening . . . harm" to others. They cannot be based simply on a diagnosis of a person's mental state, or on abstract verbalizations alone. As with involuntary parens patriae commitments, the potential for harm must arise from a "severe mental disorder" and the individual must meet the other criteria for commitment specified in subsection 6.C.

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[80] A recent draft report on commitment in Pennsylvania stresses the need for such a provision. *See* Pepe, Evaluation of the Mental Health Procedures Act (Pa. Dep't Pub. Welfare 1981), *quoted in* Appelbaum, *Civil Commitment: Is the Pendulum Changing Direction?*, 33 HOSP. & COMMUNITY PSYCHIATRY 703 (1982); *see also* Durham & Pierce, *Beyond Deinstitutionalization: A Commitment Law in Evolution*, 33 HOSP. & COMMUNITY PSYCHIATRY 216 (1982) (describing Washington State's experience).

[81] This provision should not be as constitutionally vulnerable as the old "in need of treatment" statutes. Under the Model Law, commitment requires a severe mental disorder, treatability, lack of capacity, and clear and convincing proof of likely harm. It provides for a definite term of commitment and the right to treatment. The Supreme Court in O'Connor v. Donaldson, 422 U.S. 563 (1975), did not discuss the constitutionality of such a set of commitment criteria, but decisions since then indicate that this provision should be upheld. *See, e.g.*, Doe v. Gallinot, 486 F. Supp. 983 (C.D. Cal. 1979); Reynolds v. Sheldon, 404 F. Supp. 1004 (N.D. Tex. 1975); Colorado v. Taylor, 618 P.2d 1127 (Colo. 1980).

State Involuntary Commitment Statutes

by Edward Beis

The following charts contain an overview of involuntary commitment statutes in the 50 states. The information in these charts is taken from *Mental Health and the Law* (tentative title) by Edward B. Beis, to be published by Aspen Systems Corporation in December, 1983. The book, written for mental health professionals, discusses the legal responsibilities and liabilities of psychiatrists, psychologists, psychiatric nurses and social workers, administrators, governing board members and hospitals in the delivery of outpatient and inpatient mental health care and treatment. It provides a legal perspective on mental health systems from the initiation of treatment to termination, and covers such subjects as proper medical records and the use of quality assurance and risk management programs to improve the quality of care and reduce exposure to liability. Finally, it discusses the roles of mental health professionals as expert witnesses and what is expected of them by lawyers and judges. For further information about *Mental Health and the Law*, contact Aspen Systems Corporation, 1600 Research Blvd., Rockville, Maryland 20850.

Alabama

Criteria

Mentally ill and as a consequence poses a real and present threat of substantial harm to himself or others as evidenced by a recent overt act. Ala. Code §22-52-10(a) (1982 Cum. Supp.).

Maximum Length of Disposition

None.

Alaska

Criteria

Mentally ill and likely to injure himself or others or in need of immediate care or treatment, and because of illness lacks sufficient insight or capacity to make responsible decisions concerning hospitalization. Alaska Stat. §47.30.070(i).

Maximum Length of Disposition

Indeterminate. §47.30.070(i).

Arizona

Criteria

Mental disorder and as a result poses a danger to himself or others or is gravely disabled. Ariz. Rev. Stat. Ann. §36-540 (1982 Supp. Pamph.)

Maximum Length of Disposition

Variable: 60 days to one year. §36-540.

Arkansas

Criteria

Person has a mental illness, disease or disorder and as a result is homicidal, suicidal or gravely disabled. Ark. Stat. Ann. §59-1410 (1981 Cum. Supp.).

Homicidal means the person poses a significant risk of physical harm to others as manifested by recent overt behavior evidencing homicidal or other assaultive tendencies toward others. §59-1401(a).

Suicidal means the person "poses a substantial risk of physical harms to himself as manifested by evidence of threats of, or attempt at suicide or serious self-inflicted bodily harm, or by evidence of other behavior or thoughts that create a grave and imminent risk to his physical condition. §59-1401(b).

Gravely disabled "refers to a person who is likely to injure himself or others if allowed to remain at liberty or is unable to provide for his own food, clothes, or other shelter by reason of mental illness or disorder. §59-1401(c).

Maximum Length of Disposition

Initial 45 days. §49-1409. With additional 120 days. §49-1410.

California

Criteria

Mental disorder and as a result attempted, inflicted or made a substantial threat of physical harm upon the person of another. (Cal. Welf. & Inst. Code §5300, 5304), or himself (§5213) or is gravely disabled (§5358) ("a condition in which a person, as a result of mental disorder, is unable to provide for his basic personal needs for food, clothing or shelter.") §5008(h)(i)

Maximum Length of Disposition

194 days for persons dangerous to others (§5300); 28 days for suicidal persons (§5260); and no limit for gravely disabled except dissolution of conservatorship.

Colorado

Criteria

Mentally ill and as a result person is dangerous to others, himself or is gravely disabled. Colo. Rev. Stat. Ann. §27-10-111(1).

"Mentally ill person" means a person who is of such mental condition that he is in need of medical supervision, treatment, care, or restraint. §27-10-101(7).

"Gravely disabled" means a condition in which a person, as a result of mental illness, is unable to take care of his basic personal needs or is making irrational or grossly irresponsible decisions concerning his person and lacks the capacity to understand this is so. §27-10-101(5).

Maximum Length of Disposition

12 months. §27-10-109.

Connecticut

Criteria

Mentally ill and dangerous to himself or others or gravely disabled. Conn. Gen. Stat. Ann. §17-178(c) (1982).

"Mentally ill person" means any person who has a mental or emotional condition which has substantial adverse effects on his or her ability to function and who requires care and treatment excluding drug dependence and alcoholism. §17-1.

"Dangerous to self or others" means there is a substantial risk that physical harm will be inflicted by an individual upon his or her own person or upon another person. §17-176.

"Gravely disabled" means that a person, as a result of mental or emotional impairment, is in danger of serious harm as a result of an inability or failure to provide for his or her own basic human needs such as essential food, clothing, shelter or safety and that hospital care is necessary and available and that such person is mentally incapable of determining whether or not to accept such treatment because his judgment is impaired by his mental illness. §17-176.

Maximum Length of Disposition

Duration of mental illness. §17-178(c).

Delaware

Criteria

Mental disease and poses a real and present threat to himself or others, or to property. Threat must be based upon manifest indication that person is likely to commit or suffer serious harm to himself or others or property if immediate care and treatment is not given.

"Mentally ill person" means a person suffering from a mental disease or condition which requires such person to be observed and treated at a mental hospital for his own welfare and which either (1) renders such person unable to make responsible decisions with respect to his hospitalization, or (2) poses a real and present threat, based upon manifest indications that such person is likely to commit or suffer serious harm to himself or others or to property if not given immediate hospital care and treatment.

Maximum Length of Disposition

6 months to indefinite. Del. Code Ann. tit. 16 §§5010, 5012 (1982 Cum. Supp.).

District of Columbia

Criteria

Mental illness and likely to injure himself or others. D.C. Code Ann. §21-545 (b). "Mental illness" means a psychosis or other disease which substantially impairs the mental health of a person. §21-501.

Maximum Length of Disposition

Indeterminate. §21-545(b).

Florida

Criteria

Suffers from an apparent or manifest mental illness; has refused voluntary placement, is unable to determine for himself whether placement is necessary; is "manifestly incapable of surviving alone or with the help of willing and responsible family or friends, or alternative services, and without treatment is likely to suffer from neglect or refuse to care for himself and such neglect or refusal poses a real and present threat of substantial harm to his well being or it is more likely than not that in the near future he will inflict serious harm on another person, as evidenced by behavior causing, attempting, or threatening such harm, including at least one incident thereof within 20 days prior to initiation of proceedings." Fla. Sta. Ann. §394.467 (1982).

"Mental illness" means an impairment of the emotional process, of the ability to exercise conscious con-

trol of one's actions, or of the ability to perceive reality or to understand, which impairment substantially interferes with a person's ability to meet the ordinary demands of living, regardless of etiology, excluding developmental disabilities, simple alcoholism or conditions manifested only by antisocial behavior or drug addiction. §394.455(3).

Maximum Length of Disposition

Initial 6 month period with additional six month periods. §394.467(2)(d).

Georgia

Criteria

Mental illness and a substantial risk of imminent harm to self or others (as manifested by either recent overt acts or recent expressed threats of violence which present a probability of physical injury to himself or others) or is unable to care for his own physical health and safety as to create an imminently life threatening crisis. Ga. Code Ann. §88-501(v) (1981).

Mental illness means having a disorder or thought mold which significantly impairs judgment, behavior, capacity to recognize reality or ability to cope with the ordinary demands of life. §88-501(a).

Maximum Length of Disposition

Up to 20 months. §37-38-3(d).

Hawaii

Criteria

Mental illness or substance abuse and dangerous to himself or others or to property and in need of care and treatment. Hawaii Rev. Stat. §334-60(b)(1) (1982 Supp.) Must also be least restrictive alternative.

"Mentally ill person" means a person having psychiatric disorder or other disease which substantially impairs his mental health and necessitates treatment or supervision. §334-1.

"Dangerous to other" means likely to do substantial physical or emotional injury on another, as evidenced by a recent act, attempt or threat. §334-1.

"Dangerous to self" means likely to do substantial physical injury to one's self, as evidenced by a recent act, attempt or threat to injure one's self physically or by neglect or refusal to take necessary care for one's own physical health and safety together with incompetence to determine whether treatment for mental illness or substance abuse is appropriate. §334-1.

"Dangerous to property" means inflicting, attempting or threatening imminently to inflict damage to any property in a manner which constitutes a crime, as evidenced by a recent act, attempt or threat. §334-1.

Maximum Length of Disposition

90 days. §334-60(b)(5).

Idaho

Criteria

Mentally ill and either likely to injure himself or others or is gravely disabled. Idaho Code §66-329(k) (1982).

"Likely to injure self or others" means:

(1) A substantial risk that physical harm will be inflicted by the proposed patient upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm upon himself; or

(2) A substantial risk that physical harm will be inflicted by the proposed patient upon another as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm.

"Mentally ill" shall mean a person who as a result of a substantial disorder of thought, mood, perception, orientation, or memory, which grossly impairs judgment, behavior, capacity to recognize and adapt to reality, requires care and treatment at a facility.

Gravely disabled shall mean a person who, as a result of mental illness, is in danger of serious physical harm due to the person's inability to provide for his essential needs. §66-317(1), (m), and (n).

Maximum Length of Disposition

3 years. §66-329(k).

Illinois

Criteria

Mental illness and as a result the person is reasonably expected to inflict serious physical harm on himself or another in the near future, or is unable to provide for his basic physical needs. Ill. Ann. Stat. ch. 91½. §1-119 (1983-1984).

Maximum Length of Disposition

180 days. §3-813.

Indiana

Criteria

Mentally ill and gravely disabled or dangerous and in need of custody, care or treatment. Ind. Code Ann. §16-14-9.1-10(d).

"Mental illness" means a psychiatric disorder which substantially disturbs a person's thinking, feeling, or behavior and impairs the person's ability to function. It includes mental retardation, epilepsy, alcoholism or addiction to narcotics or dangerous drugs. Iowa Code Ann. §16-14-9.1-1(a) (1983-1984).

"Gravely disabled" means a condition in which a person as a result of a mental illness is in danger of coming to harm because of his inability to provide for his food, clothing, shelter or other essential needs. §16-14-9.1-1(b).

"Dangerousness" means a condition in which a person as a result of mental illness presents a substantial risk that he will harm himself or others. §16-14-9.1-1(c).

Maximum Length of Disposition

Indeterminate. §16-14-9.1-10(d).

Iowa

Criteria

Seriously mentally impaired and is likely to injure himself or herself or other persons if allowed to remain at liberty.

"Seriously mentally impaired" means a mental illness (every type of mental disease or disorder except mental retardation) and because of illness lacks sufficient judgment to make responsible decisions with respect to his or her hospitalization or treatment, and who:

(a) is likely to physically injure himself or herself or others if allowed to remain at liberty without treatment; or

(b) is likely to inflict serious emotional injury on members of his or her family or others who lack reasonable opportunity to avoid contact with the afflicted person if the afflicted person is allowed to remain at liberty.

Serious emotional injury is an injury which does not necessarily exhibit any physical characteristics but which can be recognized and diagnosed by a licensed physician or other qualified mental health professional and which can be causally connected with the act or omission of a person who is, or is alleged to be, mentally ill. Iowa Code Ann. §299.1.1, .2. (1983-1984).

Maximum Length of Disposition

Indeterminate. §229.14.3.

Kansas

Criteria

Mentally ill person who is dangerous to himself or others or who is unable to meet his or her own basic physical needs.

(1) "Mentally ill person" means any person who is mentally impaired to the extent that such person is in need of treatment and who is dangerous to himself or herself and others, and

(a) who lacks sufficient understanding or capacity to make responsible decisions with respect to his or her need for treatment, or

(b) who refuses to seek treatment. Proof of a person's failure to meet his or her basic physical needs, to the extent that such failure threatens such person's life, shall be deemed as proof that such person is dangerous to himself or herself, except that no person who is being treated by prayer in the practice of the religion of any church which teaches reliance on spiritual means alone through prayer for healing shall be determined to be a mentally ill person unless substantial evidence is produced upon which the district court finds that the proposed patient is dangerous to himself or herself or others. Kan. Stat. Ann. §59-2902(a) (1982).

Maximum Length of Disposition

90 days. §59-2917(a).

Kentucky

Criteria

Mentally ill person who presents a danger or threat of danger to self, family, or others and can reasonably benefit from treatment. Ky. Rev. Stat. Ann. §202A.026.

"Mentally ill person" means a person with substantially impaired capacity to use self control, judgment or discretion in the conduct of his affairs and social relations, associated with maladaptive behavior or recognized emotional symptoms where impaired capacity, maladaptive behavior or emotional symptoms can be related to physiological, psychological or social factors. §202A.011(8).

"Danger" or "threat of danger to family or others" means substantial physical harm or threat of substantial physical harm upon self, family or other, including actions which deprive self, family or others of the basic means of survival including provision for reasonable shelter, food or clothing. §202A.011(2).

Maximum Length of Disposition

360 days. §202A.051.

Louisiana

Criteria

Mental illness or substance abuse which causes a person to be dangerous to self or others or gravely disabled. La. Rev. Stat. Ann. §28.55(E).

"Mentally ill" person "means any person with a psychiatric disorder which has substantial adverse effects on his ability to function and who requires care and treatment. It does not include persons suffering from mental retardation, epilepsy, alcoholism or drug abuse. §28:2(14).

"Dangerous to others" means the condition of a person whose behavior or significant threats support a reasonable expectation that there is a substantial risk that he will inflict physical harm upon another person in the near future. §28:2(3).

"Dangerous to self" means the condition of a person whose behavior, significant threats or inaction supports a reasonable expectation that there is a substantial risk that he will inflict physical or severe emotional harm upon his own person. §28:2(4).

Maximum Length of Disposition

Indeterminate. §28.56. Alcoholism 45 days (initial) and up to two 60-day periods thereafter.

Maine

Criteria

Mental illness and poses a likelihood of serious harm and inpatient hospitalization is best available means of treatment. Me. Rev. Stat. Ann. tit. 34 §2234(5).

"Mentally ill individual" means an individual having a psychiatric or other disease which substantially impairs his mental health. Does not include mentally retarded or sociopathic individuals. Does include persons suffering from drugs, narcotics, hallucinogens or intoxicants, including alcohol. 34 §2251(5).

"Likelihood of serious harm" means:

A substantial risk of physical harm to the person himself as manifested by evidence of recent threats of, or attempts at, suicide or serious bodily harm to himself, and, after consideration of less restrictive treatment settings and modalities, a determination that community resources for his care and treatment are unavailable; or

A substantial risk of physical harm to other persons as manifested by recent evidence of homicidal or other violent behavior or recent evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them and, after consideration of less restrictive treatment settings and modalities, a determination that community resources for his care and treatment are unavailable; or

A reasonable certainty that severe physical or mental impairment or injury will result to the person alleged to be mentally ill as manifested by recent evidence of his actions or behavior which demonstrate his inability to avoid or protect himself from such impairment or injury, and, after consideration of less restrictive treatment settings and modalities, a determination that suitable community resources for his care are available. 34 §2251(7).

Maximum Length of Disposition

1 year. Tit. 34 §2334(6)(A).

Maryland

Criteria

A person who has a mental disorder and needs inpatient care or treatment for the protection of self or others. Individual presents a danger to the life or safety of the individual or others. Md. Ann. Code §10-617.

Maximum Length of Disposition

Not available.

Massachusetts

Criteria

Person is mentally ill and discharge would create a likelihood of serious harm. Mass. Ann. Laws ch. 123, §8.

"Likelihood of serious harm" means:

(1) a substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm; (2) a substantial risk of physical harm to other persons, as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them; or (3) a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.

Maximum Length of Disposition

1 year. Ch. 123 §8.

Michigan

Criteria

Mentally ill person who can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or another and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation or is unable to attend to basic physical needs, such as food, clothing, or shelter that must be attended to in order for him to avoid serious harm in the near future, and who has demonstrated that inability by failing to attend to those basic physical needs. Mich. Stat. Ann. §14.800 (401(a), (b)).

"Mental illness" means a substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life. §14.800(400(a)).

A mentally ill person is one whose judgment is so impaired that he is unable to understand his need for treatment and whose continued behavior is the result of mental illness that can reasonably be expected on the basis of competent medical opinion to result in significant physical harm to himself or others. §14.800 (401(c)).

Maximum Length of Disposition

Indeterminate, following commitment periods of 60, then 90, days. §14.800 (472).

Minnesota

Criteria

Mentally ill, mentally retarded or chemically dependent person. Minn. Stat. Ann. §253B.09.

Mentally ill person means a substantial psychiatric disorder of mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, which:

(a) is manifested by instances of grossly disturbed behavior or faulty perceptions;

(b) poses a substantial likelihood of physical harm to

self or others as demonstrated by:

i. a recent attempt or threat to physically harm himself or others; or

ii. a failure to provide necessary food, clothing, shelter or medical care for himself, as a result of the impairment. §253B.02(13).

This impairment excludes (a) epilepsy, (b) mental retardation, (c) brief periods of intoxication caused by alcohol or drugs, or (d) dependence upon or addiction to any alcohol or drugs. §253B.02(13).

"Chemically dependent person" means any person (a) determined as being incapable of managing himself or his affairs by reason of the habitual and excessive use of alcohol or drugs; and (b) whose recent conduct as a result of habitual and excessive use of alcohol or drugs poses a substantial likelihood of physical harm to himself or others as demonstrated by (i) a recent attempt or threat to physically harm himself or others, (ii) evidence of recent serious physical problems, or (iii) a failure to provide necessary food, clothing, shelter, or medical care for himself. §253B.02(2).

Maximum Length of Disposition

6 months. §253B.09(5).

Mississippi

Criteria

Person afflicted with mental illness if reasonably expected at the time determination is made or within reasonable time thereafter to intentionally or unintentionally physically injure himself or others or is unable to care for himself so as to guard himself from physical injury or to provide for his own physical needs. It does not include mental retardation. Miss. Code Ann. §41-21-61.

Maximum Length of Disposition

Indeterminate. §41-21-83.

Missouri

Criteria

Mental disorder which causes the likelihood of serious physical harm to himself or others. Mo. Ann. Stat. §632.300 (Vernon 1982).

Maximum Length of Disposition

1 year, 3 months. §§632.340, .355.

Montana

Criteria

Seriously mentally ill which means suffering from a mental disorder which has resulted in self-inflicted injury to self or others or the imminent threat thereof or which has deprived the person afflicted of the ability to protect his life or health. For this purpose, injury means physical injury. No person may be involuntarily committed because he is epileptic, mentally deficient, mentally retarded, senile or suffering from a mental disorder unless the condition causes him to be seriously mentally ill. Mont. Code Ann. §53-21-102(14).

Maximum Length of Disposition

One year. §§53-21-127, 128. Thereafter, commitment proceedings must be initiated again.

Nebraska

Criteria

Mentally ill dangerous person who poses a substantial risk of serious harm to himself or others.

Mentally ill dangerous person shall mean any mentally ill person or alcoholic person who presents:

(1) a substantial risk of serious harm to another person or persons in the near future, as manifested by evidence of recent violent acts or threats of violence by placing others in reasonable fear of 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. Neb. Rev. Stat. §83-1009.

Maximum Length of Disposition

Indeterminate. §§83-1046, 83-1079.

Nevada

Criteria

A person who is mentally ill and who exhibits observable behavior that he is likely to harm himself or others if allowed to remain at liberty, or that he is gravely disabled. Nev. Rev. Stat. §433A.310(1).

Maximum Length of Disposition

6 months. §433A.310(2).

New Hampshire

Criteria

Person in such mental condition as a result of illness as to create a potentially serious likelihood of danger to himself or others. N.H. Rev. Stat. Ann. §135-B:38.

"Mental illness" means a substantial impairment of emotional processes or of the ability to exercise conscious control of one's actions, or of the ability to perceive reality or to reason, which impairment is manifested by instances of extremely abnormal behavior extremely faulty perceptions. It does not include impairment primarily caused by: (a) epilepsy; (b) mental retardation; (c) continuous or noncontinuous periods of intoxication caused by substances such as

alcohol or drugs; dependence upon or addiction to any substance such as alcohol or drugs. §135-B:2X1 (1981 Cum. Supp.).

Maximum Length of Disposition

2 years. §135-13-B:38.

New Jersey

Criteria

Person so afflicted with mental disease that he requires care and treatment for his own welfare or the welfare of others or of the community. N.J. Stat. Ann. §30:4-44, 30:4-23.

Maximum Length of Disposition

Indeterminate. N.J. Court Rule 4:74-7(f).

New Mexico

Criteria

Client with mental disorder that presents a likelihood of serious harm to himself or others, the client needs and is likely to benefit from proposed treatment consistent with least restrictive alternative.

"Mental disorder" means a substantial disorder of the person's emotional processes, thought or cognition which grossly impairs judgment, behavior or capacity to recognize reality.

Likelihood of serious harm to oneself means that it is more likely than not that in the near future the person will attempt to commit suicide or will cause serious bodily harm to himself by violent or other self-destructive means including but not limited to grave passive neglect as evidenced by behavior causing, attempting or threatening the infliction of serious bodily harm to himself.

Likelihood of serious harm to others means the person will inflict serious, unjustified bodily harm on another person or commit a criminal sexual offense as evidenced by behavior causing, attempting or threatening such harm, which behavior gives rise to a reasonable fear of such harm from said person. N.M. Stat. Ann. §§43-1-13(E), 43-1-3(L), (M), (N).

Maximum Length of Disposition

One year. §43-1-12(C).

New York

Criteria

Person who has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment. N.Y. Ment. Hyg. Law §§9.39, 9.37.

Mental illness for which immediate inpatient care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others; "likelihood of serious harm" shall mean:

(1) substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself; or

(2) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

Maximum Length of Disposition

2 years. §9.33(D).

North Carolina

Criteria

Mentally ill, mentally retarded or inebriate person who because of an accompanying behavior disorder is dangerous to himself or others, or is mentally retarded and because of accompanying behavioral disorder, is dangerous to others.

a. "Dangerous to himself" shall mean that within the recent past:

1. The person has acted in such manner as to evidence:

I. That he would be unable without care, supervision, and the continued assistance of others not otherwise available to exercise self control, judgment, and discretion in the conduct of his daily responsibilities and social relations, or to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety; and

II. That there is a reasonable probability of serious physical debilitation to him within the near future unless adequate treatment is afforded. A showing of behavior that is grossly irrational or of actions which the person is unable to control or of behavior that is grossly inappropriate to the situation or other evidence of severely impaired insight and judgment shall create a *prima facie* inference that the person is unable to care for himself; or

2. The person has attempted suicide and that there is reasonable probability of suicide unless adequate treatment is afforded under this Article; or

3. The person has mutilated himself or attempted to mutilate himself and that there is a reasonable probability of serious self-mutilation unless adequate treatment is afforded under this Article.

b. "Dangerous to others" shall mean that within the recent past, the person has inflicted or threatened to inflict serious bodily harm on another or has acted in such a manner as to create a substantial risk of serious bodily harm to another and that there is a reasonable probability that such conduct will be repeated. N.C. Gen. Stat. §122.58.2.

Maximum Length of Disposition

90 days. §122-58.8.

North Dakota

Criteria

Mentally ill persons requiring treatment.

"Mentally ill person" means an individual with an organic, mental, or emotional disorder which substantially impairs the capacity to use self-control, judgment, and discretion in the conduct of personal affairs and social relations. Does not include mentally retarded.

"Person requiring treatment means either:

a. A person who is mentally ill, an alcoholic or a drug addict and who as a result of such condition can reasonably be expected within the near future to intentionally or unintentionally seriously physically harm himself or another person and who has engaged in an act or acts or made significant threats that are substantially supportive of this expectation; or

b. A person who is mentally ill, an alcoholic or a drug addict and who as a result of such condition is unable to attend to his basic physical needs, such as food, clothing or shelter that must be attended to for him to avoid serious harm in the near future, and who has demonstrated that inability by failing to meet those basic physical needs. N.D. Cent. Code §25-03.1-02.

Maximum Length of Disposition

90 days. §25-03.1-22.

Ohio

Criteria

Mentally ill person who creates a substantial risk of physical harm to himself or others, or who would benefit from treatment.

(A) "Mental illness" means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.

(B) "Mentally ill person subject to hospitalization by court order" means a mentally ill person who, because of his illness:

(1) Represents a substantial risk of physical harm to himself as manifested by evidence of threats of, or attempts at, suicide or serious self-inflicted bodily harm;

(2) Represents a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness;

(3) Represents a substantial and immediate risk of serious physical impairment or injury to himself as manifested by evidence that he is unable to provide for and is not providing for his basic physical needs because of his mental illness and that appropriate provision for such needs cannot be made immediately available in the community; or

(4) Would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself. Ohio Rev. Code Ann. §5122.01.

Maximum Length of Disposition

Two years. §5122.15(H).

Oklahoma

Criteria

A person who has a mental illness and in the near future can be expected to intentionally or unintentionally harm himself or others or is unable to care for his basic physical needs.

(c)"Mentally ill person" means any person afflicted with a substantial disorder of thought, mood, perception, psychological orientation or memory that significantly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life;

(o) "Person requiring treatment" means either:

(1) A person who has a demonstrable mental illness and who as a result of that mental illness can be expected within the near future to intentionally or unintentionally seriously and physically injure himself or another person and who has engaged in one or more recent overt acts or made significant recent threats that substantially support that expectation; or

(2) A person who has a demonstrable mental illness and who as a result of that mental illness is unable to attend to those of his basic physical needs such as food, clothing or shelter that must be attended to in order for him to avoid serious harm in the near future and who has demonstrated such inability by failing to attend to those basic physical needs in the recent past; but

(3) Person requiring treatment shall not mean a person whose mental processes have simply been weakened or impaired by reason of advanced years, a mentally deficient person or a person with epilepsy unless the person also meets the criteria set forth in this paragraph. However, the person may be hospitalized under the voluntary admission provisions of this act if he is deemed clinically suitable and a fit subject for care and treatment by the person in charge of the facility. Okla. Stat. Ann. tit. 43A §54.3(o).

Maximum Length of Disposition

Indeterminate. Tit. 43A §73.

Oregon

Criteria

Mentally ill person who is dangerous to himself or others or is unable to provide for his own basic personal needs. A mentally ill person means a person who, because of a mental disorder, is either:

(a) dangerous to himself or others; or

(b) unable to provide for his basic personal needs and is not receiving such care as is necessary for his health or safety. Or. Rev. Stat. §426.005.

Maximum Length of Disposition

180 days. §426.130.

Pennsylvania

Criteria

A severely mentally disabled person who poses a clear and present danger to others or himself.

(a) Whenever a person is severely mentally disabled and in need of immediate treatment, he may be made subject to involuntary emergency examination and treatment. A person is severely mentally disabled when, as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger of harm to others or to himself.

(1) Clear and present danger to others shall be shown by establishing that within the past 30 days the person has inflicted or attempted to inflict serious bodily harm on another and that there is a reasonable probability that such conduct will be repeated. If, however, the person has been found incompetent to be tried or has been acquitted by reason of lack of criminal responsibility on charges arising from conduct involving infliction of or attempt to inflict substantial bodily harm on another, such 30-day limitation shall not apply so long as an application for examination and treatment is filed within 30 days after the date of such determination or verdict. In such case, a clear and present danger to others may be shown by establishing that the conduct charged in the criminal proceeding did occur, and that there is a reasonable probability that such conduct will be repeated. For the purpose of this section, a clear and present danger of harm to others may be demonstrated by proof that the person has made threats of harm and has committed acts in furtherance of the threat to commit harm.

(2) Clear and present danger to himself shall be shown by establishing that within the past 30 days:

(i) the person has acted in such manner as to evidence that he would be unable, without care, supervision and the continued assistance of others, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety, and that there is a reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days unless adequate treatment were afforded under this act; or

(ii) The person has attempted suicide and that there is a reasonable probability of suicide unless adequate treatment is afforded under this act. For the purposes of this subsection, a clear and present danger may be demonstrated by the proof that the person has made threats to commit suicide and has committed acts which are in furtherance of the threat to commit suicide; or

(iii) the person has substantially mutilated himself or attempted to mutilate himself substantially and that there is the reasonable probability of mutilation unless adequate treatment is afforded under this act. For the purposes of this subsection, a clear and present danger shall be established by proof that the person has made threats to commit mutilation and has committed acts which are in furtherance of the threat to commit mutilation. Pa. Stat. Ann. tit. 50 §7301.

Maximum Length of Disposition

90 days. Up to one year if criminal charges involving dangerous acts. Tit. 50 §7304(g).

Rhode Island

Criteria

A person who is so insane as to be dangerous to the peace or safety of the people of the state or so as to render his restraint and treatment necessary for his own welfare. R.I. Gen. Laws §40.1-5.1-1.

Maximum Length of Disposition

Indeterminate. §40.1-5.1-3.

South Carolina

Criteria

A person who is mentally ill, needs treatment and because of his condition:

(1) lacks sufficient insight or capacity to make responsible decisions with respect to his treatment; or

(2) there is a likelihood of serious harm to himself or others. S.C. Code Ann. §44-17-580 (1982 Cum. Supp.).

Maximum Length of Disposition

Indeterminate. §44-17-820.

South Dakota

Criteria

Mentally ill person who lacks sufficient understanding and capacity to meet the ordinary demands of life or is dangerous to himself or others. S.D. Codified Laws Ann. §27A-1-1. The term "mentally ill" as used in this title includes any person whose mental condition is such that his behavior establishes one or more of the following:

(1) He lacks sufficient understanding or capacity to make responsible decisions concerning his person so as to interfere grossly with his capacity to meet the ordinary demands of life; or

(2) He is a danger to himself or others.

Maximum Length of Disposition

Indeterminate. §27A-9-18.

Tennessee

Criteria

A person is mentally ill and poses a likelihood of serious harm and is in need of care and treatment. Tenn. Code Ann. §33-604(a), (d).

Likelihood of serious harm" means:

(1) A substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at, suicide or serious bodily harm; or

(2) A substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in a reasonable fear of violent behavior and serious physical harm to them; or

(3) A reasonable certainty that severe impairment or injury will result to the person alleged to be mentally ill as manifested by his inability to avoid or protect himself from such impairment or injury and suitable community resources for his care are unavailable. §33-604.

Maximum Length of Disposition

Indefinite. §§5547-52(b).

Texas

Criteria

A person who is mentally ill and requires hospitalization for his own welfare and protection or the welfare and protection of others. Tex. Rev. Civ. Stat. Ann. §§5547-52(b).

Mentally ill person means a person whose mental health is substantially impaired. §5547-4(k).

Maximum Length of Disposition

Indefinite. §5547-52(b).

Utah

Criteria

(a) The proposed patient has a mental illness; and

(b) Because of the patient's illness the proposed patient poses an immediate danger of physical injury to others or self, which may include the inability to provide the basic necessities of life, such as food, clothing, and shelter, if allowed to remain at liberty; and

(c) The patient lacks the ability to engage in a rational decision-making process regarding the acceptance of mental treatment as demonstrated by evidence of inability to weigh the possible costs and benefits of treatment; and

(d) There is no appropriate less restrictive alternative to a court order of hospitalization. Utah Code Ann. §64-7-36(10).

"Mental illness" means a psychiatric disorder as defined by the current *Diagnostic and Statistical Manual of Mental Disorder* which substantially impairs a person's mental, emotional, behavioral or related functioning. §64-7-28(1).

Maximum Length of Disposition

Indeterminate. §64-7-36(11)(a).

Vermont

Criteria

(17) "A person in need of treatment" means a person who is suffering from mental illness and, as a result of that mental illness, his capacity to exercise self-control, judgment, or discretion in the conduct of his affairs and social relations is so lessened that he poses a danger of harm to himself or others;

(A) A danger of harm to others may be shown by establishing that:

(i) he has inflicted or attempted to inflict bodily harm on another; or

(ii) by his threats or actions he has placed others in reasonable fear of physical harm to themselves; or

(iii) by his actions or inactions he has presented a danger to persons in his care.

(B) A danger of harm to himself may be shown by establishing that:

(i) he has threatened or attempted suicide or serious bodily harm; or

(ii) he has behaved in such a manner as to indicate that he is unable, without supervision and the assistance of others, to satisfy his need for nourishment, personal or medical care, shelter or self-protection and safety, so that it is probable that death, substantial bodily injury, serious mental deterioration or serious physical debilitation or disease will ensue unless adequate treatment is afforded.

(14) "Mental illness" means a substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but shall not include mental retardation. Vt. Stat. Ann. tit. 18 §7101 (17).

Maximum Length of Disposition

Indeterminate. §7621.

Virginia

Criteria

A person who (a) presents an imminent danger to himself or others as a result of mental illness, or (b) has otherwise been proven to be so seriously mentally ill as to be substantially unable to care for himself, and (c) that there is no less restrictive alternative to institutional confinement and treatment and that the alternatives to involuntary hospitalization were investigated and were deemed not suitable. Va. Code §37.1-67.3 (1982 Cum. Supp.)

Maximum Length of Disposition

180 days. §37.1-67.3.

Washington

Criteria

A person who has threatened, attempted, or inflicted: (a) physical harm upon the person of another or himself, or substantial damage upon the property of another, and (b) as a result of mental disorder presents a likelihood of serious harm to others or himself; or

(2) Such person was taken into custody as a result of conduct in which he attempted or inflicted harm upon the persons of another or himself, and continues to present, as a result of mental disorder, a likelihood of serious harm to others or himself.

(3) Such person has been determined to be incompetent and criminal charges have been dismissed and has committed acts constituting a felony, and as a result of a mental disorder, presents a substantial likelihood of repeating similar acts. In any proceeding pursuant to this subsection it shall not be necessary to show intent, willfulness or state of mind as an element of the felony; or

(4) Such person is gravely disabled. Wash. Rev. Code Ann. §71.05.280 (1982).

"Gravely disabled" means a condition in which a person, as a result of mental disorder: (a) is in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety. §71.05.020(1).

"Mental disorder" means any organic, mental or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions. §71.05.020(2).

"Likelihood of serious harm" means either: (a) A substantial risk that physical harm will be inflicted by an individual upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on one's self, (b) a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm, or (c) a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others. §71.05.020(3).

Maximum Length of Disposition

180 days. §71.05.320.

West Virginia

Criteria

Mental illness, retarded or addicted and is likely to cause serious harm to himself or to others. Mental illness means a manifestation in a person of significantly impaired capacity to maintain acceptable rules of functioning in the areas of intellect, emotion and physical well being. W.Va. Code Ann. §27-1-2.

"Likely to cause serious harm" refers to a person who has:

(1) A substantial tendency to physically harm himself which is manifested by threats of or attempts at suicide or serious bodily harm or other conduct, either active or passive, which demonstrates that he is dangerous to himself; or

(2) A substantial tendency to physically harm other persons which is manifested by homicidal or other violent behavior which places others in reasonable fear of serious physical harm; or

(3) A complete inability to care for himself by reason of mental retardation; or

(4) Become incapacitated. §27-1-12.

Maximum Length of Disposition

2 years. §27-5-4(k)-4.

Wisconsin

Criteria

(1) A person who is mentally ill, drug dependent, or developmentally disabled and is a proper subject for treatment: and

(2) Is dangerous because the individual:

(a) Evidences a substantial probability of physical harm to himself or herself as manifested by evidence of recent threats of or attempts at suicide or serious bodily harm;

(b) Evidences a substantial probability of physical harm to other individuals as manifested by evidence of recent homicidal or other violent behavior, or by evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, as evidenced by a recent overt act, attempt or threat to do . . . serious physical harm;

(c) Evidences such impaired judgment, manifested by evidence of a pattern of recent acts or omissions, that there is a . . . substantial probability of physical impairment or injury to himself or herself. The probability of physical impairment or injury . . . *is not* substantial under this subparagraph if reasonable provision for the subject individual's protection is available in the community, . . . if the individual is appropriate for placement under s. 55.06 or, in the case of a minor, if the individual is appropriate for services or placement under s. 48.13(4) or (11). The subject individual's status as a minor does not automatically establish a . . . substantial probability of physical impairment or injury under this subparagraph; or

(d) Evidences behavior manifested by recent acts or omissions that, due to mental illness, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treat-

ment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness. Wisc. Stat. Ann. §51.20(1) (West).

Maximum Length of Disposition

One year. §51.20(13)(g).

Wyoming

Criteria

A person is mentally ill based on evidence of recent overt acts, or threats. Wyo. Stat. §25-10-110. A mentally ill person means a person who presents an imminent threat of physical harm to himself or others as a result of a physical emotional, mental or behavioral disorder which grossly impairs his ability to function socially, vocationally or interpersonally and who needs treatment and who cannot comprehend the need for or purposes of treatment and with respect to whom the potential risk and benefits are such that a reasonable person would consent to treatment. §25-10-101.

Maximum Length of Disposition

Indeterminate. §25-10-116.

Conspiracy suit

(continued from p. 334)

an influence on the termination decision."

The court stated that it would be difficult to prove a conspiracy between the association and state officials, but that there was "sufficient evidence to raise a factual issue on this claim." The court also stated that if the former superintendent had succeeded in establishing a conspiracy, the first amendment would not shield the association from liability, but that the state would be immune from retrospective monetary responsibility under the eleventh amendment. State officials, acting within the scope of their discretionary authority, would forfeit their immunity by acting with malicious intention to cause deprivation of constitutional rights, or, even if acting in sincere subjective belief that they were doing right, if their actions contravened "'settled indisputable law.'" ■

Table of Cases

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HAVING IT BOTH WAYS: SURVEYING THE AREA BETWEEN LEAST RESTRICTIVE ALTERNATIVE AND WRONGFUL DISCHARGE

William C. Rein, J.D. (1)

Mental health professionals, especially in public practice, are undergoing what must appear to them as an invasion of their professional sphere by the law. Major revisions to the Kansas Act for obtaining Care and Treatment For Mentally Ill Persons in July of 1976 have resulted in attorneys and judges becoming increasingly involved in both admissions and discharge decisions at state psychiatric facilities (2). Today virtually every mental health professional in institutional service must be a forensic professional. Front-line professionals spend a substantial amount of time preparing for judicial proceedings. Moreover, forensic services are no longer reserved for specific wards. Routine reporting deadlines and actual court testimony are often required equally of professionals working in criminal-civil, juvenile-adult, and open-security settings. To a large extent, it is often the law which affects the balance between therapy and forensic services, both of which must be provided by mental health professionals.

Within this context of increased judicial activity comes a theory of law which holds mental health professionals responsible for acts of physical violence committed by their patients. Who should be responsible when one person kills another, and what rules should apply to holding one other than the killer responsible?

The Past Two Decades

For the past twenty years, mental health law has focused on procedural and substantive requirements for involuntary psychiatric treatment. A number of early cases looked at the initiation of involuntary treatment to determine the minimum constitutional requirements of procedural due process for the admission decision (3). Other cases followed the committed patient inside the institution and attempted to define the minimum requirements of appropriate treatment (4). Finally, a third set of cases examined procedural issues surrounding the least restrictive treatment alternative in areas such as seclusion and restraint, behavior therapy, and administrative transfers from one program to another (5). Most of the legal decisions and legislative enactments during the past decade insured that patients would not be involuntarily committed unless all other reasonable alternatives had been exhausted.

Patients' liberty emerged most often as the paramount protected interest. This resulted from successful arguments that criminal law, with its preference for eyewitness testimony and overt behavior, was the proper blueprint for the conduct of commitment proceedings (6). Further, psychiatric testimony, previously unchallenged, was no longer accepted without thoughtful inquiry, especially in light of some academic studies finding that psychiatrists had difficulty in predicting dangerous behavior (7). Psychiatric testimony based on "subjective impression" was limited and viewed by a growing number of attorneys as hearsay (6,8). Finally, psychiatrists were restricted to testifying on recent behavior since the "dangerous" acts of the proposed patient were to be treated as if offered in a criminal trial. (The law has maintained in criminal actions that prior crimes are not to be admitted into evidence. If admissible, prior crimes would have a prejudicial effect upon the determination of whether or not the defendant committed a specific crime (8,9). As a result, some judges in commitment cases were persuaded to ignore incidents more than a few weeks, months, or years old.

The trend of limiting psychiatric testimony to "clinical" opinions, outside the scope of the "ultimate issue of fact" (mentally ill as defined by law, legally insane, competent to stand trial), continued largely unabated in academic circles until a new legal theory of liability emerged (10). While the old lines of reasoning championed the patients' liberty above all other competing interests, the new reasoning attempted to protect the public interest in safety from dangerous acts committed by patients.

Professional Liability for Wrongful Discharge

"Wrongful discharge" and "duty to warn" are the popular names given to cases that deal with professional malpractice in providing mental health services. "Patients' liberty" and "wrongful discharge" theories developed simultaneously, one stressing the patient's right to return to the community as soon as possible and the other acknowledging the public's right to be protected from the patient's dangerous acts. The evidentiary tools for making the discharge decision are as contradictory in practice as the interests they represent. For example, in civil commitment cases, patients' attorneys argue that psychiatrists can not predict anything and everything psychiatrists say outside of direct observation is hearsay. In wrongful discharge cases, however, plaintiffs' attorneys argue that psychiatrists can predict everything and that nothing of psychiatric history is hearsay.

The Meaning of Wrongful Discharge

The legal action that supports psychiatric liability for wrongful discharge perhaps had its most celebrated pronouncement in the California Tarsoff ruling (11). The Tarsoff case and its progeny have been viewed as requiring a warning from a therapist if a patient threatens to harm a readily identifiable third party. Post Tarsoff cases focused upon three elements in determining whether or not a therapist would be held liable for injuries caused by a former patient: whether the therapist knew that a patient was threatening harm; whether a readily identifiable third party was a risk by the patient's threats; and whether a proper warning was given by the therapist to the threatened party. Obviously, the therapist's "duty to warn" a third party of possible danger inherently forced the divulgence of previously confidential information obtained during threatment. Nonetheless, in this specific interface between law and psychiatry, protection of innocent members of the community took priority over confidentiality.

There is little doubt that Tarasoff actually required "due care" from the mental health professionals in dealing with the issue of dangerousness, even though it is often referred to as a "duty to warn" case. The requirement of law for reasonable care in professional practice is well settled, and perhaps should have caused little debate when stated in Tarasoff. However, the difficulty of predicting dangerousness and the ethical demands for therapeutic confidentiality led many to question whether it was reasonable to expect warnings, or any other protective measure, in many of the cases that came before the courts.

In many respects, "wrongful discharge" cases must address the same three issues as "duty to warn" cases. In fact, wrongful discharge merely expands the third element of "duty to warn" by requiring physical control of the patient (i.e., maintaining continued hospitalization). In effect, if a therapist in an institutional setting is of the opinion that a patient poses a threat to some other member of the community, the therapist must continue the patient in hospitalization rather than warning an individual of possible danger.

Beyond these basic elements, there is the general principle that one person is not liable for the acts of another unless some special relationship exists between the two so as to make substituted liability fundamentally fair (12). Indeed, parents are not normally liable for the injurious actions of their children, despite the most fundamental of special relationships existing between the two, unless the parents cooperate, or in some way encourage their children's acts (13). Nonetheless, in duty to warn and wrongful discharge cases, the law has found that a special relationship exists between mental health professionals and patients so that professionals have a duty to safeguard community members from anticipated dangerous actions (14).

There are two policy reasons for this form of third party liability. First, the profession of medicine, like those of law and theology, requires many years of special study, has an internal policing code of ethics, and is dedicated to public service. The law recognizes that physicians owe a duty to the general community in specific circumstances of high public risk, such as the duty to protect others from their patients' contagious diseases (15). The idea of the physician as a public servant who should act to protect other members of society is not a new concept in the law. Second, duty to warn and wrongful discharge spring from the concept of latent dangers. Latent dangers are dangers that are not apparent to the threatened person so that he or she is not able to avoid the hazard through the use of common sense. For example, no one needs to warn a person of suitable age not to touch a hot stove. The eyes and mind can both perceive that the stove is hot, and common sense resulting from practical experience is its own warning of danger. However, in duty to warn and wrongful discharge cases, the mental health professional may be the only one who knows that a threat of harm exists. Therefore, due to the latent nature of the danger and duty to the community, the law would exact a warning from the professional to the party at risk.

Wrongful Discharge in Kansas

In 1983, the Kansas Supreme Court was asked to determine whether or not wrongful discharge was a valid cause of action under Kansas Law. In a lengthy decision delivered by Justice McFarland, the court responded in the affirmative: "We recognize as a valid cause of action, a claim which grew out of the negligent release of a patient who had violent propensities, from a state institution, as distinguished from negligent failure to warn persons who might be injured by the patient as a result of the release" (16). The underlying facts that resulted in this decision are stated as follows.

In 1973, Bradley Durflinger, a 19-year old man whose immediate family resided in Oregon, was living with his grandparents in Hutchinson, Kansas. One evening, his grandparents went out and left him at home. While they were gone, Durflinger formed the mental intent to kill them and steal their automobile. He obtained a hatchet and a meat fork with which he intended to kill his grandparents when they returned. Durflinger abandoned this intent however, and merely told his grandparents what he had thought about doing.

The next day, Durflinger's grandparents sought an order of treatment in the Reno County District Court that was subsequently granted. Durflinger was committed to Larned State Hospital for treatment where he was diagnosed as having a personality disorder without psychotic features. Durflinger was discharged three months later. He then returned to Oregon where he shot and killed his mother and younger brother.

The importance of Durflinger may lie not so much with the recognition of the cause of action itself but rather the manner in which its underlying facts compare to the issues stated previously from the Tarasoff line of cases. A brief analysis along these lines may be helpful.

At the time of his discharge, the professional staff who treated Durflinger knew that he had formed the mental intent to harm his grandparents, but they knew that he had abandoned his intent also. Nonetheless, it could be argued that the treating staff knew that Durflinger had threatened to harm another person. However, Durflinger had never threatened his mother and brother according to treating staff. Therefore, the concept of a "readily identifiable third party" at risk would have dictated that the grandparents were the subject of necessary protective action. Finally, this case was not the result of any "latent" danger, in that both Mr. Durflinger's immediate and extended family were aware of the incidents surrounding admission.

Perhaps the critical issue in past cases, the extent to which the therapist knew that a readily identifiable third party was at risk by a patient's future behavior, has evolved to whether the therapist "should have known". Moreover, the "readily identifiable third party" may now extend to "anyone whose harm was reasonably foreseeable". In any event, it is likely that these basic issues will continue to provide a focal point for evaluating future cases of psychiatric malpractice.

Recent Cases From Other States

Although Kansas has recognized wrongful discharge as a cause of action grounded in medical malpractice, there is a growing body of case law that clearly distinguishes ordinary medical decisions from psychiatric discharge decisions. Two recent cases, Brady v. Hopper and Sherrill v. Wilson, cite the strong legal push on psychiatry during the past decade to discharge patients as soon as possible and the difficulty of predicting dangerous behavior (17).

Brady dealt with the attempted assassination of President Reagan in 1981. Although the U.S. District Court for the District of Colorado recognized that "the therapist-patient relationship is one which under certain circumstances will give rise to a duty on the part of the therapist to protect third parties from harm", the court went on to note that the duty owed was not to "the world at large" (18). The court further held that "unless a patient makes specific threats, the possibility that he may inflict injury on another is vague, speculative, and a matter of conjucture" (19). Finally, the court concluded that there were "cogent policy reasons for limiting the scope of the therapist's liability", similar to those stated in the Sherrill case which follows (20).

In Sherrill, a wrongful death action was brought against treating physicians of a patient who killed while on a two-day pass from a state mental hospital in Missouri. The Missouri Supreme Court, in rejecting a mere medical malpractice theory, concluded that the physicians should not be held liable "simply because they might be found to have exercised negligent professional judgment" in allowing their patient a two-day pass from the hospital (21). This case favorably discusses the whole current of mental health law during the past decade (e.g., patients have a right to the least restrictive treatment alternative, the community benefits from attempting to return patients to productive living situations as soon as possible). Subjecting professionals to the threat of liability in their daily practice for negligence in release decisions might be a greater wrong to society as a whole than allowing for errors in professional judgment in individual release decisions.

Confidentiality vs. Protective Disclosure of Treatment Information

All wrongful discharge cases, regardless of the applicable burden of proof, pose difficulties for mental health professionals in ascertaining the limits of their personal accountability. It must be asked at the moment professional services are rendered: To whom is the therapist responsible? Is it the patient or the public? If both, what of the potential for divided loyalties?

Much has been written about the implications of duty to warn and wrongful discharge theories on the therapist-patient relationship. The need for strict confidence that exists in any therapeutic relationship cannot be passed over lightly. Certainly, it is often difficulties in relating with other persons that cause the patient to seek professional help. If the therapist has to disclose some of these extremely personal thoughts, patients might be unwilling to seek help. In addition, the therapist's desire to establish treatment in the least restrictive setting might be chilled by fear that the patient might disregard established support systems in favor of acting in a violent manner.

Predicting Dangerousness: The issue of foreseeability

Just as much has been written about problems of accountability in the development of wrongful discharge theories of liability, so has the issue of foreseeability been equally well addressed. In most cases, the issue of foreseeability has been discussed under the general lable of "the failure to predict future dangerous behavior". Obviously, mental health professionals will only be responsible for actions that are reasonably foreseeable from everything known to them, or from things that should have been known to them through reasonable professional efforts.

There are many practical problems inherent in predicting human behavior. First of all, there are simply too many variables over which therapists have little control following the discharge of patients. For example, life stressors such as family disputes, employment terminations, physical illness, and a myriad of other problems may occur with little warning. While it may be reasonable to expect a mental health professional to predict such things as a continued inability to maintain employment, life of petty crime, transient life-style, or refusal to seek treatment on a voluntary basis, it may be much more difficult to predict whether or not the same individual will ever kill. Killing is an infrequent life event and as such is extremely difficult to predict. Finally, the results of many studies confirm the difficulty faced by mental health professionals in predicting dangerous behavior of former patients (7).

Causes of Dangerous Behavior

Of primary concern to mental health professionals at the present time is identifying which dangerous actions of their former patients may result in personal liability. Are clinicians to be held liable for all dangerous actions of their patients that might have been foreseen, or only those resulting from a recognizable illness that is likely to respond favorably to psychiatric treatment? This core issue has been poorly defined by both case law and state statutes.

The law does not clearly distinguish "dangerous by choice" from "dangerous by reason of treatable mental illness". It is not proper to speak simply in terms of liability for wrongful discharge of "dangerous mental patients". In Lipari v. Sears, Roebuck and Company the court commented that "the Nebraska Supreme Court has imposed on hospitals a duty to guard against their patients dangerous mental conditions when the condition is discoverable by the exercise of reasonable care" (emphasis added) (23). On the surface, the statement "dangerous mental conditions" seems to communicate something of importance. However, it may actually communicate nothing at all.

Following the reasoning of the Lipari court, it might be asked, whether all acts of violence are not the result of a dangerous mental condition. Certainly, there is no doubt that an individual who has lost complete contact with reality by reason of a severe psychotic condition, and kills in that mental state, suffered at the time from a "dangerous mental condition". Is an individual who kills while robbing a convenience store any less controlled by his "dangerous mental condition"? In both cases, the act of killing came from the mind as opposed to any other part of the physical being. This is the ultimate problem facing mental health professionals. The problem is especially acute because courts have found liability for the discharge of psychotic individuals as well as persons suffering from "personality disorders" that are not likely to respond to standard psychiatric intervention.

Who Decides Treatment or Punishment

In this country, there are two forms of social control available to county and district attorneys when faced with dangerous actions of community members. Indeed, it is most often the county attorney who decides whether a given set of facts will result in filing for criminal prosecution or in applying for determination of mental illness. Unquestionably, many habitual criminals without psychotic illnesses are committed to state psychiatric hospitals. When committed, such persons are most often given the diagnosis of Antisocial Personality Disorder which rarely responds to psychiatric treatment. Sometimes these persons are committed merely because they have received treatment in the past or because plea negotiations have resulted in psychiatric commitment. Rarely do such patients see any need to change their antisocial style of living.

To some degree, courts feel bound to maintain these persons in state hospitals for further "safekeeping", even though treatment is not likely to succeed, because of the provisions of state law. For example, the provisions of K.S.A. 22-3428 (commitment of insanity acquittees) indicate that the persons who have been found not guilty by reason of insanity shall remain in state psychiatric hospitals until "no longer dangerous to self, others or a substantial danger to the property of others". Similarly, the provisions of K.S.A. 22-3430 (treatment in lieu of sentencing) require a finding by the committing court that the convicted defendant is no longer dangerous before sentencing can be imposed (24). Thus, the law does not distinguish between "dangerous by choice" and "dangerous by reason of treatable mental illness". The result of this lack of distinction is that state hospitals are forced to house a number of persons who are dangerous but will not benefit from psychiatric treatment.

Regardless of whether an individual is adjudicated "criminal", "not guilty by reason of insanity", or "mentally ill as defined by law", the issues of dangerousness and reasonable likelihood of a favorable response to psychiatric treatment are always the same. In many cases, individuals who have been committed to state psychiatric facilities, through the civil or criminal process, are deemed to be potentially dangerous under specific circumstances but not by reason of any treatable mental impairment. If dangerousness is the only issue of importance to society, then the idea of psychiatric hospitals existing for the treatment of mental illness becomes almost irrelevant. If dangerousness is the only point of focus for mental health professsionals, psychiatric treatment facilities could hardly be distinguished from correctional facilities, except to the extent that discharge decisions might hold such professionals subject to medical malpractice litigation under the framework of "wrongful discharge".

Society is accustomed to the idea that certain antisocial acts (crimes) should be subject to maximum penalties beyond which actors must be released back into society as "having paid their just debt". As such, correctional inmates are discharged not because they are no longer dangerous, but merely because society has predetermined that certain acts should be subject to certain maximum penalties. If the distinction between "dangerous by reason of treatable mental impairment" and "dangerous by reason of willful choice" is maintained in practice, then distinctions between discharge of penal inmates from correctional facilities and patients from state psychiatric facilities make legitimate sense. Otherwise, involuntary civil commitment is redundant.

Often mental health professionals are presented with involuntary patients who are dangerous to others but who will not benefit from even the best psychiatric intervention. In criminal cases, judges have sometimes indicated that they feel certain individuals should not be subjected to the rigors of penal confinement, are not really as bad as the criminal actions might make them seem, or need help with alcohol or drug related problems. What these judges may fail to realize is that underneath the drug abuse is an antisocial personality that will not respond to treatment. Commitment in these cases will be of little benefit to either the defendant or society. Moreover, the problem is compounded by the fact that many insanity determinations are not truly contested. Some of the cases are little more than stipulated pleas upon negotiated dispositions between the defense and prosecuting attorney. This may result from the fact that prosecutors realize that defendants may be more fully locked out of society by committing them to psychiatric treatment facilities than would be the case if sentenced to prison. However, if these individuals cannot be discharged from psychiatric facilities until proven "no longer dangerous", and if hospital initiated discharge may result in professional liability for wrongful discharge due to later antisocial behavior, such individuals may be expected to remain virtually forever in a psychiatric hospital without substantial need of or benefit from treatment.

Suggestions That Won't Work

Many suggestions have been made to address the mental health professional's predicament by the wrongful discharge theory. In involuntary cases, it has often been argued that professionals should defer to court order before discharging committed patients. This results from the impression that judges are immune from discharge liability and, therefore should be asked to make discharge decisions. Others have argued that hospitals should establish better internal systems of review before patients are discharged by institutional physicians. Either of these might be an acceptable solution if dangerousness is the only issue of importance, however, mental health professionals are faced with the practical truth that treatment must be addressed if psychiatric hospitals are to remain therapeutic. Moreover, as long as patients have constitutional or statutory rights to treatment in the least restrictive setting, hospitals can not passively wait for courts to make decisions at specified intervals.

It is unlikely that courts will consistently distinguish dangerousness from need for treatment. Deferring to courts might only create a back-log of patients waiting to gain judicial access for discharge decisions. Moreover, a passive position would undoubtedly result in the creation of artificial or "paper only" differences between penal institutions and psychiatric hospitals since both would be expected to provide "safekeeping" for dangerous persons.

The issue is much more complex than simply creating review mechanisms designed to assure that dangerous mental patients are not discharged from treatment facilities. If such mechanisms are adhered to, the problem may shift to one of serious institutional overcrowding by persons not in need of psychiatric intervention.

Conclusion

If two methods of social control are to be justified in this country, the basic distinction between persons who commit violent acts by reason of willful choice (criminal prosecution), and persons who commit violent acts by reason of some recognizable mental illness that might respond to psychiatric treatment (civil commitment), must be maintained in law. If the distinction cannot be reestablished, a single entry system within the code of criminal procedure seems to be the only alternative to safeguard the delicate balance between least restrictive alternative and wrongful discharge.

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(2) KAN. STAT. 59-2901, et. seq.

(3) Lessard v. Schmidt, 349 F.Supp. 1078 (E.D. Wis. 1972), vacated, 414 U.S. 473 (1974), on remand, 379 F.Supp. 1376 (E.D. Wis. 1974), vacated, 421 U.S. 957 (1975), on remand, 413 F.Supp. 1318 (E.D. Wis., 1976); Lynch v. Baxley, 386 F.Supp. 378 (M.D. Ala. 1974); O'Connor v. Donaldson, 422 U.S. 563, 45 L.Ed. 2d 396, 95 S.Ct. 2486 (1975).

(4) Wyatt v. Stickney, 325 F.Supp. 781 (M.D. Ala. 1971); Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966).

(5) Vitek v. Jones, 445 U.S. 480, 63 L.Ed. 2d 552, 100 S. Ct. 1254 (1980).

(6) American Bar Association, Commission on the Mentally Disabled. (1977) Legal issues in state mental health care: Proposals for change-Civil commitment. Mental Disability Law Reporter, 2

(7) Ennis, B.J. (1972). Prisoners of Psychiatry. New York: Harcourt Brace Jovanovich, Inc.

(8) Mental Disability Law Reporter, 2 (1), Supra Note 6 at 98.

(9) Rathbum, R.K., & Renn, C.M. (1977). Evidence of other crimes in Kansas. Washburn Law Journal, 17, pp. 98 to 124 ; KAN. STAT. 60-455.

(10) Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 131 Cal. Rptr. 14, 551 p.2d 334 (1976), 83 A.L.R. 3d 1166; Durflinger, et.al. v. Artiles, et al., 234 Kan. 484, 673 p.2d 86 (1983).

(11) Tarasoff, Supra Note 10.

(12) Prossor, W.L (1977). Law of Torts (4th ed.). pp. 871-72 St. Paul: West

(13) Id; See also KAN. STAT. 38-120

(14) Restatement (2d) of Torts, 315 (1965)

(15) Durflinger, Supra Note 10 at 495.

(16) Id at 499.

(17) Brady v. Hopper, 570 F. Supp 1333 (D. Colo. 1983); Sherrill v. Wilson, 653 S.W. 2d 661 (Mo. Supp. Ct. 1983).

(18) Brady, Supra Note 17 at 1338.

(19) Id.

(20) Id. at 1339.

(21) Sherrill, Supra Note 17 at 667.

(22) Lipari v. Sears, Roebuck, and Company. 497 F. Supp. 185 (D. Neb. 1980).

(23) Lipari, Supra Note 23 at 191.

(24) However, see State v. Smith, 3 Kan. App. 2d 179 (1979) for the proposition that district courts retain inherent jurisdiction to amend K.S.A. 22-3430 orders whenever it reasonably appears to committing judges that defendants are not likely to benefit from further psychiatric treatment.