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The Law of Civil Commitment in Pennsylvania: Towards a Consistent Interpretation of the Mental Health Procedures Act

Steven B. Datlof*

One cold winter's night, Maxwell Edison, a junior premedical student at the University of Philadelphia, was brought to the Emergency Room of the Hospital of the University of Philadelphia (HUPh) by his girlfriend, Joan. Max created a disturbance in the waiting room, loudly and angrily hurling abusive epithets at Joan, whom he accused of tricking him into coming to the hospital when he believed they were going to the movies.

Joan told the Emergency Room physician, and then the psychiatrist on call, Dr. Sigmund, of Max's increasingly bizarre behavior. Max had not been sleeping or eating well for several days, Joan related. In addition, he had stopped attending classes and doing his schoolwork. He was drinking heavily, smoking

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1. THE BEATLES, Maxwell's Silver Hammer, on Abbey Road (EMI Records 1969). With apologies to the Beatles. In the song, Maxwell Edison murders his girlfriend Joan and his teacher with a silver hammer.

2. All names of institutions in this vignette are fictitious.
marijuana daily, and Joan thought he might be abusing other drugs as well. His conversations were rambling and nonsensical, usually having something to do with a "silver hammer" that Max insisted was a sign from God that he was the new Messiah. He talked about his expectation of imminent death and resurrection in such a way that Joan feared he was considering suicide. Joan also told the psychiatrist that she was afraid of Max; his temper had grown short, and he frequently took offense at casual, innocuous remarks, misconstruing them as insults. Furthermore, he had struck Joan in the course of an outburst six weeks ago, leaving her with a black eye and various cuts and bruises.

When Dr. Sigmund questioned Max, he initially responded in a guarded fashion. Gradually, however, he became more expansive, and ultimately he corroborated the information related by Joan.

The doctor gave Max a diagnosis of "Substance-Induced Psychotic Disorder, rule out Manic-Depressive Disorder." He recommended that Max be admitted to the hospital for inpatient treatment consisting of psychotherapy and medication. Faced with this recommendation, Max's anger escalated. He adamantly refused hospitalization, insisting, "I'm not a nut-case!"

Joan was incredulous when Dr. Sigmund accepted Max's decision. She reiterated her fear of Max, and requested to petition to involuntarily commit Max to the hospital. The doctor was sympathetic, but said there was nothing he could do: Max's behavior did not meet the criteria for involuntary commitment. Dr. Sigmund explained that he had tried many times in the past to get patients like Max involuntarily committed, but unless the patient had actually threatened to harm himself or someone else, and had taken concrete steps to carry out the threats within the past thirty days, the court always denied the commitment. Moreover, the court would not involuntarily commit a patient whose primary mental disorder was related to drug or alcohol problems. He suggested that Joan contact Women in Crisis if she needed a safe haven, away from Max.

Walking home, Max continued to lambaste Joan with verbal abuse. Finally he stalked off, saying that he was going to the movies. Instead, Max hitchhiked a ride back to his hometown of

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3. Substance-Induced Psychotic Disorder is characterized by prominent delusions or hallucinations caused by drug intoxication or withdrawal. Diagnostic and Statistical Manual of Mental Disorders Fourth Edition DSM-IV 310-15 (1994) [hereinafter DSM-IV]. Bipolar disorder, manic phase is a mood disorder characterized by expansive or irritable mood, grandiosity, decreased need for sleep, and disorganization of thinking. Id. at 328-32.
Hamburg, seventy-five miles northwest of Philadelphia in Berks County. At 4:00 a.m. his parents were awakened by a loud knocking on the front door. After listening to several minutes of wild discourse about silver hammers and the apocalypse, Mr. and Mrs. Edison drove Max to the local Emergency Room. He was then involuntarily committed to the psychiatric ward of the hospital.

How is it that Dr. Sigmund of HUPh deemed Max as ineligible for involuntary commitment where a mere four hours later, Max was involuntarily committed in Hamburg? Pursuant to answering this question, Part I of this article will review the development of the modern law of civil commitment in Pennsylvania. The Pennsylvania legislature responded to societal trends favoring individual autonomy over paternalism and to United States Supreme Court decisions protecting individual liberties with the Mental Health Procedures Act (PMHPA) of 1976. This Act established that a severely mentally ill individual could only be involuntarily committed if he was proven dangerous to himself or others.

Part II considers inconsistencies in the interpretation of the PMHPA and in its application to involuntary commitment. The Act excludes “senile, alcoholic, or drug dependent” persons from its definition of severe mental illness. Individuals with no additional psychiatric diagnoses thus are ineligible for involuntary commitment. These exclusions stem from outdated medical concepts and currently create confusion and serve no useful purpose. The legislature should therefore amend the PMHPA to remove these exclusions.

Part II further considers the PMHPA’s “clear and present danger” standard for proving dangerousness. Because Pennsylvania courts interpret the standard inconsistently, individuals with similar behaviors may be committed for involuntary treatment while others are released. Moreover, mental health review officers in urban centers tend to interpret the standard such that proving dangerousness is exceedingly difficult. This article recommends a consistent interpretation of the clear and present danger standard based on the plain meaning of the PMHPA. The Act states that clear and present danger to oneself or others may be demonstrated by threats of harm and acts in furtherance of these threats.

5. Title 50 § 7301.
6. Id. § 7102.
7. Id. § 7301.
8. See infra notes 127-35 and accompanying text for discussion of how clear and
PMHPA's wording does not compel a court to conclude that the clear and present danger standard can be met only if threats and acts in furtherance of threats are revealed. Rather, the legislature intended to allow courts to determine whether the clear and present danger standard was met without the restrictions of a rigid formula. Such a reading of the PMHPA will allow courts discretion to balance individuals' rights with the need to protect severely mentally ill individuals from causing harm to themselves and society.

I. DEVELOPMENT OF CIVIL COMMITMENT LAW IN PENNSYLVANIA

The protection of the rights of the individual against the government is a basic tenet of the United States Constitution. Yet, society has recognized that there are situations when vulnerable individuals must be protected, and when the rights of the individual must be restricted for the good of society as a whole. Hence there exists a tension in our society, reflected in American jurisprudence, between an individual's right to exercise autonomy in decision-making, and society's right to paternalistically make decisions for that individual. Nowhere is this dichotomous tension more evident than in the areas of mental health treatment and mental health law, as exemplified by the problem of involuntary commitment of the mentally ill.

By definition, an involuntary commitment is considered when an individual refuses voluntary psychiatric hospitalization. Thus, the individual at the very least disagrees with mental health professionals, and possibly his family as well, about his need for hospitalization. He may also disagree, at a more basic level, about his need for any treatment or whether he is in fact mentally ill.

For most of the twentieth century, however, Pennsylvania, like most American jurisdictions, followed a paternalistic, present danger may be demonstrated under the PMHPA.


10. See Ralph Reisner & Christopher Slobogin, Law and the Mental Health System 611-12 (2d ed. 1990) (comparing law of civil commitment with criminal law, and citing latter as example of area of law where interests of society are paramount).

11. Id.


13. Id. at 95.
"need-for-treatment" based standard for involuntary commitment.\textsuperscript{14} According to this standard, states' authority to involuntarily commit an individual stemmed from the "parens patriae" and "police power" doctrines.\textsuperscript{15} Under the "parens patriae" principle, the state could act for the good of the individual, to mandate inpatient treatment for mental illness when doctors believed that such treatment was necessary to restore the individual's health.\textsuperscript{16} Under the "police power" doctrine, states also reserved the authority to involuntarily commit a mentally ill individual for the good of society, to protect others from harm.\textsuperscript{17}

Implicit in commitment standards based on parens patriae and police power doctrines was deference to the medical profession and trust in the judgment of physicians.\textsuperscript{18} Pennsylvania's Mental Health Act of 1951 followed this deferential standard.\textsuperscript{19} This Act permitted the involuntary commitment to a mental health facility of persons "thought to be mentally ill and in need of observation, diagnosis, and treatment" when two physicians affirmed the need for such commitment.\textsuperscript{20} Largely because of the Kennedy era impetus to provide more decentralized, community-based services for the mentally ill,\textsuperscript{21} the Pennsylvania legislature revised the 1951 Act in 1966.\textsuperscript{22} The resulting Pennsylvania Mental Health and Mental Retardation Act (PMHMRA) adhered to the earlier Act's standard for commitment of "mentally ill" individuals based on need for treatment.\textsuperscript{23}

\textsuperscript{14} REISNER, supra note 10, at 599; see also Bruce A. Arrigo, Paternalism, Civil Commitment and Illness Politics: Assessing the Current Debate and Outlining a Future Direction, 7 J. L. & HEALTH 131, 136-37 (1992/93) (discussing historical development of paternalistic, need-for-treatment based commitment laws).

\textsuperscript{15} See Arrigo, supra note 14, at 137-39 (discussing "parens patriae" and "police power" doctrines); John E.B. Myers, Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change, 29 VILL. L. REV. 367, 380-88 (1983/84) (discussing same doctrines).

\textsuperscript{16} See Arrigo, supra note 14, at 136-37.

\textsuperscript{17} See id.

\textsuperscript{18} See id. at 136 (discussing deference to physicians as part of a "need-for-treatment" approach to civil commitment justified under parens patriae and police power doctrines).

\textsuperscript{19} 1951 Pa. Laws §§ 326-332.

\textsuperscript{20} Id. § 326.


\textsuperscript{22} PA. STAT. ANN. tit. 50 §§ 4101-4704 (West 1969) (repealed in part 1976).

\textsuperscript{23} Title 50 §§ 4404-4406 (repealed in part 1976). Section 4404 provided that "[a] written application for commitment to a facility may be made in the interest of any person who appears to be mentally disabled and in need of care." Id. § 4404. Section 4404 further required that "[s]uch application shall be accompanied by the certificates of two physicians . . . who have found that . . . such person is mentally disabled and in need of care." Id. Section 4406 permitted involuntary commitment through a civil court hearing of similar individuals "believed to be mentally disabled, and in need of care or treatment." Id. §
A. The United States Supreme Court Protects Individual Rights in Civil Commitment Cases

In the 1970's, societal trends favoring individual autonomy and denigrating paternalism fostered challenges to need-for-treatment based civil commitment statutes. The groundwork for change was laid by the United States Supreme Court in the 1972 case Humphrey v. Cady. The Humphrey Court highlighted the seriousness of the constitutional issues involved in civil commitment in recognizing that commitment involves a "massive curtailment of liberty." Moreover, the Court concluded that involuntary commitment could not be justified "solely on the medical judgment that the defendant is mentally ill and treatable [without also showing] that his potential for doing harm, to himself or others, is great enough to justify such a massive curtailment of liberty."

Humphrey thus articulated the constitutional rights at issue in civil commitments. Later in 1972, the Humphrey analysis was applied for the first time in a constitutional challenge to a state's civil commitment law. In Lessard v. Schmidt, the United States District Court for the Eastern District of Wisconsin considered a class action contesting the constitutionality of Wisconsin's civil commitment law. The plaintiffs alleged the law violated their due process rights because it failed "to describe the standard of commitment so that persons may be able to ascertain the standard of conduct under which they may be detained with reasonable certainty." The court agreed, declaring that the statute unconstitutionally allowed commitment without proof that the

4406. See infra notes 41-56 and accompanying text for further discussion of the PMHMRA of 1966, in particular noting the extreme paternalism inherent in section 4404, allowing involuntary commitment of an individual without the protection of any judicial proceeding.


26. Humphrey, 405 U.S. at 509. Humphrey concerned an equal protection claim brought by a sexual offender convicted under the Wisconsin Sex Crimes Act. Id. at 506. The plaintiff claimed that as a mentally ill sexual offender, he was involuntarily committed to a psychiatric facility without the procedural protections afforded to non-criminal mentally ill individuals under the Wisconsin Mental Health Act. Id. at 508.

27. Id.


30. Id.
individual was beyond a reasonable doubt both mentally ill and dangerous.\textsuperscript{31}

Three years after \textit{Lessard}, in \textit{O'Connor v. Donaldson},\textsuperscript{32} the Supreme Court applied the “mentally ill plus dangerous” standard to the commitment of a schizophrenic patient confined against his will in a Florida state hospital for fifteen years.\textsuperscript{33} Given uncontroverted evidence that the patient had never posed a danger to himself or others, the Court held that the forced hospitalization violated his constitutional right to freedom.\textsuperscript{34}

While the \textit{O'Connor} Court thus established “mentally ill plus dangerous” as the constitutionally acceptable standard for involuntary commitment, the question of the standard of proof required under the due process clause to commit an individual remained to be settled by \textit{Addington v. Texas}.\textsuperscript{35} The \textit{Addington} Court opined that the reasonable doubt standard was too difficult for the state to meet given the uncertainties of psychiatric diagnosis.\textsuperscript{36} The Court was wary of imposing a standard so stringent that the result would be “an unreasonable barrier to needed medical treatment.”\textsuperscript{37} At the same time, the requirements of due process necessitated a standard higher than the preponderance of the evidence standard applicable to other civil cases.\textsuperscript{38} Chief Justice Burger, writing a unanimous opinion, therefore concluded that the standard of clear and convincing evidence struck the proper balance between protecting the liberties of the individual and the needs of the state.\textsuperscript{39}

The impact of the \textit{Humphrey-O'Connor-Addington} line of cases on involuntary commitment laws has been dramatic. One commentator notes that by 1990, virtually all states had replaced “mental illness plus need for treatment” statutes with laws that prescribe “mental illness plus dangerousness” as the standard for civil commitment.\textsuperscript{40}

\textsuperscript{31.} Id. at 1103.
\textsuperscript{32.} 422 U.S. 563 (1975).
\textsuperscript{33.} \textit{O'Connor}, 422 U.S. at 564-65.
\textsuperscript{34.} Id. at 575.
\textsuperscript{35.} 441 U.S. 418.
\textsuperscript{36.} \textit{Addington}, 441 U.S. at 432.
\textsuperscript{37.} Id.
\textsuperscript{38.} Id. at 432-33.
\textsuperscript{39.} Id. at 431.
\textsuperscript{40.} REISNER supra note 10, at 601; see Hermann, supra note 12, at 106 n.60 (citing Alabama, Washington D.C., Hawaii, Kentucky, Maine, Maryland, New Hampshire, New Mexico, North Carolina, Pennsylvania, Tennessee, and West Virginia as examples of jurisdictions limiting involuntary commitment to those mentally ill individuals who are
B. Pennsylvania Courts Respond to the Winds of Change

Pennsylvania kept pace with the national trends in civil commitment law. In 1971, in *Dixon v. Attorney General of Pennsylvania,* the United States District Court for the Middle District of Pennsylvania struck down Section 4404 of the PMIIMRA under the due process clause of the Fourteenth Amendment. Section 4404 allowed involuntary commitment of an individual upon the certification of two physicians that the person needed care, without requiring any court proceedings. In *Dixon,* seven patients involuntarily committed to Farview State Hospital pursuant to Section 4404 challenged its constitutionality in a class action suit. The plaintiffs originally were confined to Farview, a maximum-security forensic psychiatric facility, on criminal convictions. After the convictions terminated, the plaintiffs were committed indefinitely to Farview under Section 4404.

The tone of the *Dixon* court conveyed outrage that the plaintiffs were thus deprived of their liberty without benefit of representation by counsel and without any judicial proceedings. The court reviewed Supreme Court cases where these due process protections were afforded defendants in criminal and juvenile delinquency proceedings, and reasoned that the same procedural protections should be guaranteed in civil commitments. In concluding that Section 4404 was unconstitutional on its face, the undivided court found the statute "almost completely devoid of the due process of law required by the Fourteenth Amendment."

The Middle District of Pennsylvania also invalidated Section 4406 of the PMHMRMA five years later, in *Goldy v. Beal.* In contrast with Section 4404's provision for commitment by two physicians without a court proceeding, Section 4406 provided a court hearing as an

dangerous to themselves or others).

44. *Dixon,* 325 F. Supp. at 967.
45. *Id.* at 967-69.
46. *Id.* at 967-68.
47. *Id.* at 972-73. The court's opinion includes a verbatim exchange between Judge Biggs and defense counsel, in which Judge Biggs is incredulous that a mere "paper notation" was sufficient to accomplish the commitment, and that no formal hearing was required. *Id.*
48. *Id.* at 971-72 (citing Application of Gault, 387 U.S. 1 (1967); Specht v. Patterson, 386 U.S. 605 (1967)).
50. *Id.* at 972.
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alternate method for involuntary commitment.\(^\text{52}\) While procedural protections had been the issue in Dixon, in Goldy the court scrutinized the constitutionality of the PMHMRA's "mental illness plus need for treatment" standard for involuntarily commitment.\(^\text{53}\) The Goldy court found this standard unconstitutionally vague.\(^\text{54}\) Judge Nealon's opinion for a unanimous three-judge court criticized the vagueness of Section 4406, noting it provided no guidelines about the severity of illness required to make a patient committable, and gave no guidance about the type of treatment that was needed.\(^\text{55}\) He reasoned that such vagueness could easily result in arbitrary enforcement of the statute, and that such an arbitrary interference with an individual's constitutionally protected right of physical liberty violated due process.\(^\text{56}\) With its civil commitment statute thus declared unconstitutional, the Pennsylvania legislature had no choice but to enact a new law in accordance with the constitutionally accepted "mental illness plus dangerousness" standard for commitment.

C. The Pennsylvania Mental Health Procedures Act of 1976

In July of 1976, the Pennsylvania legislature repealed Section 4406 of the PMHMRA and enacted the Mental Health Procedures Act (PMHPA), the law governing civil commitment that remains in force today.\(^\text{57}\) The PMHPA differs from its predecessor in several ways. First, the PMHPA provides that only "severe" mental illness warrants involuntary commitment.\(^\text{58}\) The statute, however, does not define "severe."\(^\text{59}\) Second, in addition to demonstrating severe mental illness, the state must also prove the individual dangerous to herself or others in order to warrant involuntary commitment.\(^\text{60}\) Third, the individual's dangerousness to oneself or others must be "clear and present."\(^\text{61}\)

The PMHPA provides that clear and present danger to others must be shown "by establishing that within the past 30 days the person has inflicted or attempted to inflict serious bodily harm on

\(^{52}\) PA STAT. ANN. tit. 50 § 4406 (West 1998) (repealed in part 1976).
\(^{54}\) Id.
\(^{55}\) Id. at 648.
\(^{56}\) Id.
\(^{57}\) PA STAT. ANN. tit. 50, §§ 7101-7503 (West 1998).
\(^{58}\) Title 50, § 7301.
\(^{59}\) Id.
\(^{60}\) Id.
\(^{61}\) Id.
another and that there is a reasonable probability that such conduct will be repeated.\textsuperscript{62} The Act then provides an example of how such clear and present danger to others may be demonstrated, without mandating that the danger must be shown in this fashion: "[A] clear and present danger of harm to others \textit{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."\textsuperscript{63}

A clear and present danger of harm to oneself must be established in one of three ways: either by showing that the person is unable to care for himself, that the person has attempted suicide, or that he has substantially mutilated himself.\textsuperscript{64} An individual who is unable to care for himself may be involuntary committed only if there is a "reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within thirty days unless adequate treatment were afforded under this act."\textsuperscript{65} A person who has attempted suicide or mutilated himself may be committed only if there is a reasonable probability of a repeat of the self-injurious behavior.\textsuperscript{66} Clear and present danger of suicide \textit{may be} demonstrated by proof that the individual has made threats to commit suicide and has taken action in furtherance of these threats.\textsuperscript{67} By contrast, the PMHPA mandates that clear and present danger of self-mutilation "\textit{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."\textsuperscript{68}

II. INCONSISTENCY IN THE INTERPRETATION OF THE PMHPA

The PMHPA establishes two absolute requirements for involuntary civil commitment: severe mental illness and clear and present danger of serious harm to oneself or others as a result of such mental illness.\textsuperscript{69} The PMHPA is difficult to apply in practice, however, because it provides no specific definition of mental illness and because the clear and present danger standard is vague.

\textsuperscript{62} Id.
\textsuperscript{63} Title 50, § 7301 (italics added).
\textsuperscript{64} Id.
\textsuperscript{65} Id.
\textsuperscript{66} Id.
\textsuperscript{67} Id. (italics added).
\textsuperscript{68} Title 50, § 7301 (italics added). See \textit{infra} notes 123-38 and accompanying text for discussion of the significance of PMHPA's explicit wording regarding whether threats and acts in furtherance of threats are necessary to establish clear and present danger.
\textsuperscript{69} Id.
A. What Constitutes Mental Illness for the Purposes of the PMHPA?

The PMHPA fails to define what constitutes mental illness except to exclude certain conditions from the definition: "Persons who are . . . senile, alcoholic, or drug dependent shall receive mental health treatment only if they are also diagnosed as mentally ill, but these conditions of themselves shall not be deemed to constitute mental illness." Because the excluded conditions themselves are not defined by the PMHPA, the exclusions merely add to the confusion in defining what does constitute mental illness for the purposes of the statute.

Senility, moreover, has no actual medical definition. Webster's Dictionary defines senile as "exhibiting a loss of mental faculties associated with old age." Psychiatry classifies these changes of aging along a continuum, from benign forgetfulness that is part of the normal aging process to debilitating conditions characterized by multiple cognitive deficits known as "dementias." To further complicate matters, the most common dementia, Alzheimer's Disease, was historically and still is commonly known as "Senile Dementia." Dementias, however, are clearly considered by psychiatry to constitute mental disorders. At least some senile conditions are therefore also classified by psychiatry as mental disorders and accordingly should not be excluded from the PMHPA's definition of mental illness.

Not surprisingly, courts struggle with how to deal with cognitively impaired elderly persons who are subjects of involuntary commitment proceedings. Psychiatrists who frequently testify at commitment hearings and mental health review officers authorized to conduct commitment hearings understand the

70. Id. § 7102.
72. WEBSTER'S SEVENTH NEW COLLEGIATE DICTIONARY 789 (1965).
74. DSM-IV, supra note 3, at 133.
75. Id. at 137.
76. DSM-III, supra note 3, at 137.
77. DSM-III, supra note 3, at 133-55.
78. See infra notes 79-93 and accompanying text for discussion of this issue.
PMHPA as excluding dementias from its definition of mental illness. Psychiatrists will often use an alternate diagnosis to avoid the risk of a review officer declining to commit an individual because the doctor attributes the dangerous behavior solely to dementia.

Few Pennsylvania cases have considered the practical problems associated with the exclusion of senility from the PMHPA's definition of mental illness. In 1980, the Allegheny Court of Common Pleas provided guidance on the meaning of senility for PMHPA purposes in *In re Rodgers.* Timothy Rodgers appealed his involuntary commitment, arguing that his diagnosis of "organic brain syndrome of a psychotic degree" was indistinguishable from senility and therefore could not be grounds for commitment.

The court disagreed, concluding that organic brain syndrome with psychosis differs significantly from senility. In thus holding that Rodgers' condition came under the rubric of the PMHPA, the court opined that the Pennsylvania legislature intended to exclude "senility as that word is commonly understood, the benign changes of age . . . without a loss of ability to function as to reality;" it was not excluding "senility with psychosis."

The holding of *Rodgers,* therefore, clearly means that an individual with dementia who is overtly psychotic — out of touch with reality — comes under the purview of the PMHPA. Left unanswered by *Rodgers* is whether a demented person with

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81. Interview with Kenneth Certa, M.D., *supra* note 80.


83. Psychiatric diagnosis has traditionally considered dementia to be one of the Organic Brain Syndromes. The term has been dropped by DSM-IV to avoid the confusion that resulted from the implication that these conditions were caused by specific abnormalities of the brain whereas other psychiatric conditions such as schizophrenia and manic-depressive disorder were not. DSM-IV *supra* note 3, at 123. Psychosis is usually defined as a disorder of thinking characterized by the presence of delusions, hallucinations, or gross disorganization of thought processes. *Id.* at 770. Delusions are false beliefs based on incorrect inferences about external reality. *Id.* at 765. Hallucinations are false perceptions that occur without external stimulation of the relevant sensory organ. *Id.* at 767.


85. *Id.* at 97.

86. *Id.* at 95.

87. *Id.* at 97.

88. *See supra* notes 70-77, 80 and accompanying text for discussion of psychiatric definitions of dementia.

89. *See supra* note 83 for discussion of psychiatric definitions of psychosis.
non-psychotic behavioral problems that could lead to a clear and present danger to oneself or others, such as severe agitation or belligerent behavior, also would be committable.

The Pennsylvania Superior Court provided a tentative answer to this question in In re Remley. The Remley court reversed the involuntary commitment of an eighty-two year old man with a diagnosis of "senility," finding no evidence of his dangerousness. The court's analysis focused on the individual's lack of dangerousness, not on whether he was mentally ill. The implication of the court's rationale is that had the individual been dangerous, the court would have allowed his commitment, regardless of whether he suffered merely from dementia. This emphasis on the PMHPA's dangerousness requirement for civil commitment and de-emphasis on the mental illness requirement is consistent with a recent United States Supreme Court decision in civil commitment law.

Remley effectively provides that the clause excluding senility from the PMHPA's coverage is irrelevant. Given that senility has no clear meaning, and that dementias are considered mental illnesses, the clause is confusing and anachronistic. The legislature should therefore amend the statute to delete this clause.

The clause indicating that alcohol and drug dependence do not constitute mental illness under the PMHPA is similarly confusing

92. Id.
93. Id.
94. In Kansas v. Hendricks, 521 U.S. 346 (1997), a man with a long history of sexually molesting children was committed under the Kansas Sexually Violent Predator Act. Id. at 350. This Act allowed the commitment of persons who, due to a "mental abnormality" or "personality disorder" were deemed likely to engage in "predatory acts of sexual violence." Id. The Kansas Supreme Court struck down the Act, holding that an individual must be mentally ill in order to be involuntarily committed. Id. Because a "mental abnormality" was not "mental illness," the Act failed to meet due process requirements for civil commitment, according to the Kansas court. Id. The Supreme Court reversed. Id. In his majority opinion, Justice Thomas emphasized society's right to override an individual's constitutionally protected liberty interest when the individual poses "a danger to the public health and safety." Id. at 357. This balancing of interests in favor of protecting the public led Justice Thomas to conclude that a "mental abnormality" is sufficient constitutional grounds for involuntary commitment of those unable to control their dangerousness. Id. at 356-59. He insisted that "the term 'mental illness' is devoid of any talismanic significance." Id. at 359. That is, while dangerousness by itself would not be enough to justify commitment, the Court left to the state legislatures the task of deciding the type of mental problem required and the definition of such condition. Id. at 358-59. Thus, Hendricks clearly gives the states the constitutional authority to loosen the mental illness requirement as long as the dangerousness requirement for commitment is maintained.
and also should be deleted. Alcohol and drug dependence are considered mental illnesses by current psychiatric diagnostic standards. Psychiatrists, however, will often use additional diagnoses when attempting to involuntarily commit patients with these disorders. This is because psychiatrists and mental health review officers understand the PMHPA to exempt persons with the sole diagnosis of alcohol or drug dependence from involuntary commitment.

*Mervan v. Darrell,* decided by the United States District Court for the Eastern District of Pennsylvania, illustrates that courts sometimes simply ignore the PMHPA's exclusion of alcohol dependence. In *Mervan,* the plaintiff was hospitalized after intentionally ingesting antifreeze in an attempt to force his mother to give him the car keys so he could drive to the store to purchase beer. Before discharge from the hospital, he was told that the antifreeze had damaged his liver and kidneys, and that continued drinking would therefore "eventually kill him." After discharge, Mervan promptly resumed drinking alcohol. At the behest of his mother, he was then involuntarily committed. The social worker who filled out the warrant cited the dangers posed to Mervan by alcohol consumption as the main reason for commitment. There was no mention in the warrant of mental illness other than alcohol abuse nor was there any mention of threats to harm himself or others. At the commitment hearing, the review officer similarly cited Mervan's alcohol consumption and its potentially fatal consequences. The review officer then concluded that Mervan was severely mentally disabled and authorized a twenty day commitment.

The plaintiff failed to appeal the review officer's decision. Rather, he brought suit in district court alleging violation of his First, Fourth, and Fourteenth Amendment rights under 42 U.S.C. §

95. DSM-IV, supra note 3, at 176-183.
96. Interview with Kenneth Certa, M.D., supra note 80.
97. Id.
100. Id.
101. Id.
102. Id. at *2.
103. Id.
105. Id.
106. Id.
107. Id. at *6.
1983; false imprisonment; and that civil proceedings had been
wrongfully initiated against him. Because he neglected to appeal
the commitment, the plaintiff was estopped from relitigating the
review officer's findings that he was severely mentally disabled and
in need of involuntary commitment. In addition, defendant social
workers successfully asserted a qualified good faith immunity
defense to the Section 1983 claim.

By declining to reconsider the review officer's findings, the
district court avoided having to address the issue of whether the
plaintiff's commitment truly met the PMHPA standard. Mervan had
no diagnosis of mental illness other than alcohol problems, and
thus should not have qualified as "severely mentally ill" under the
statute. Thus, Mervan illustrates that despite the PMHPA's
exclusion of alcohol dependence, courts and review officers still
may lean toward allowing a commitment although the mental
illness at issue is alcohol related, if the court finds the individual's
behavior meets the dangerousness criterion. While such decisions
are understandable because modern psychiatry classifies alcohol
and drug dependence as mental disorders, unilateral
non-compliance with the statute results in inconsistency in court
decisions, in the decisions of mental health review officers, and in
diagnostic confusion by psychiatrists. The problem could easily be
solved by removing the clause excluding alcohol and drug
dependence from the PMHPA.

B. How Clear is the Clear and Present Danger Standard?

There is more case law about the standard for dangerousness
than about the definition of mental illness under the PMHPA. Even
so, only one case about the dangerousness standard has reached
the Pennsylvania Supreme Court. In Gibson v. DiGiacinto, the
court overturned the involuntary commitment of an individual who

108. Id. at *2. Defendants included two social workers, individually and as employees
of Northampton County Emergency Services; five police officers, individually and as officers
of the Bethlehem Police Department, a psychiatrist, and an emergency room physician. Id. at
*1-2.


110. Id. at *4.

111. In Mervan, the plaintiff actually may not have met the dangerousness criterion
either, given the evidence of dangerousness was based merely on a vague prediction of
premature demise because of alcohol consumption. Id. at *2, *6. See infra notes 112-36 and
accompanying text for further discussion of the clear and present danger standard.

had been committed to a psychiatric facility from prison.113 According to a petition filed by the prison warden, the appellant refused to take his medication, extinguished a burning newspaper in his cell, and was found possessing a twisted piece of a coathanger.114 The mental health review officer and subsequently the court of common pleas and the superior court all found these behaviors constituted acceptable grounds for commitment.115

The Pennsylvania Supreme Court, however, opined that none of these behaviors provided evidence of an overt act of suicide or self-mutilation, or the infliction or threat of serious bodily harm to others.116 Nor was there any evidence that the appellant was unable to care for himself.117 Therefore, the court overturned the commitment order, despite the psychiatrist's testimony that the appellant suffered from schizophrenia with paranoid delusions.118 In so doing the court followed the PMHPA's dictate that mental illness by itself is not sufficient to justify commitment—evidence of dangerousness must be present as well.

That the Gibson court reversed a commitment upheld by two lower courts highlights the difficulty interpreting the clear and present danger standard. Indeed, commentators have noted that lower Pennsylvania courts have interpreted "clear and present danger" differently from Gibson in cases with similar fact patterns.119 For example, in Platt v. Platt,120 the Pennsylvania Superior Court considered whether to uphold a commitment of a "delusional" woman manifesting bizarre behavior.121 The documented behavior consisted of throwing a jar of Noxzema in the bathroom, throwing a chair in the direction of one of her children,122 burning some of her son's belongings when she became angry with him, and striking or attempting to strike her children during temper tantrums.123 While ultimately remanding for further

114. Id. at 106.
115. Id.
116. Id. at 106-07.
117. Id.
121. Platt, 404 A.2d at 417.
122. Whether appellant was trying to hit the child was disputed. Id. at 420 (Hoffman, J., dissenting).
123. Id. at 417-18.
evidence, the Platt court opined that these acts "certainly would be sufficient for a review officer or a court to conclude that the appellant posed a 'clear and present danger' to others."\textsuperscript{124}

The dissent disagreed, insisting there was no evidence to show that the appellant inflicted serious harm on another.\textsuperscript{125} The dissent further argued that the appellant had made no threats against her family and her conduct was provoked by the children.\textsuperscript{126} In the dissent's view, the absence of threats of harm or acts in furtherance of threats was a pivotal factor in determining that the appellant's behavior did not rise to the level of a clear and present danger.\textsuperscript{127} Pennsylvania courts are divided regarding whether such threats and acts in furtherance of threats are necessary to establish dangerousness.

In 1986, Superior Court Judge Beck remarked in Commonwealth \textit{v.} Helms\textsuperscript{128} that the PMHPA specifically "does not require 'threats of harm' and commission of 'acts in furtherance of the threat to commit harm' as a condition precedent for finding 'clear and present danger.'"\textsuperscript{129} The Act states that threats and acts "may" be used to demonstrate dangerousness, not that they "shall" be used.\textsuperscript{130} Judge Beck therefore concluded that threats and acts are merely one possible way to demonstrate dangerousness.\textsuperscript{131} The PMHPA uses the same wording regarding the use of threats and acts to establish clear and present danger in the section on danger to others and in the section on suicide.\textsuperscript{132} By contrast, in the section on self-mutilation, the PMHPA states "clear and present danger \textit{shall} be established" by threats or acts in furtherance of the threats.\textsuperscript{133} Thus, Judge Beck concluded that the legislature intended to mandate the method of proving clear and present danger only in

\begin{itemize}
\item \textsuperscript{124} Id. at 418.
\item \textsuperscript{125} Id. at 420 (Hoffman, J., dissenting).
\item \textsuperscript{126} Id. (Hoffman, J., dissenting).
\item \textsuperscript{127} Platt, 404 A.2d at 420. (Hoffman, J., dissenting).
\item \textsuperscript{128} 506 A.2d 1384 (Pa. Super. 1986).
\item \textsuperscript{129} Helms, 506 A.2d at 1388.
\item \textsuperscript{130} Id.
\item \textsuperscript{131} Id. at 1388-89.
\item \textsuperscript{132} "[A] clear and present danger of harm to others \textit{may be demonstrated} by proof that the person has made threats of harm and has committed acts in furtherance of the threats to commit harm." \textit{Pa. Stat. Ann. tit. 50, § 7301} (West 1998) (italics added). "[A] clear and present danger \textit{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." \textit{Id.} (italics added).
\item \textsuperscript{133} Title 50, § 7301.
\end{itemize}
the situation of self-mutilation.\textsuperscript{134}

Despite Judge Beck's cogent discussion of the statutory language in \textit{Helms}, subsequent decisions have held that threats and acts in furtherance of the threats are necessary to establish clear and present danger to oneself or others. In 1997, the Superior Court in \textit{In re Woodside}\textsuperscript{135} quoted the same language cited by Judge Beck, yet reached the opposite conclusion about its meaning: "Here, appellant's commitment was premised on the latter sentence of this section, \textit{requiring} a threat and acts in furtherance of the threat."\textsuperscript{136}

The inconsistent interpretation by Pennsylvania courts of the clear and present danger standard is even more pronounced at initial commitment proceedings conducted by mental health review officers throughout the state.\textsuperscript{137} The interpretation of the standard varies widely by locality.\textsuperscript{138} Urban centers employ a stringent standard that makes proof of clear and present danger extremely difficult,\textsuperscript{139} while rural counties are more likely to interpret the standard flexibly.\textsuperscript{140} In Philadelphia, review officers follow the \textit{Woodside} interpretation,\textsuperscript{141} requiring a threat and clearly demonstrable acts in furtherance of the threat in order to commit a person.\textsuperscript{142} Outside Philadelphia, the \textit{Helms} reading\textsuperscript{143} of the PMHPA is more common.\textsuperscript{144} While review officers in these counties still look for threats and acts in furtherance of the threats, they tend to define such acts more loosely than review officers in Philadelphia.\textsuperscript{145} Greater deference in rural counties is therefore accorded to a psychiatrist's judgment in determining whether an individual needs commitment for his safety or for the safety of others.\textsuperscript{146} This difference in approach is consistent with a greater emphasis on individual rights and patient autonomy in urban centers, and a more paternalistic view towards patients in rural areas.\textsuperscript{147}

\begin{itemize}
\item \textsuperscript{134} \textit{Helms}, 506 A.2d at 1388.
\item \textsuperscript{135} 699 A.2d 1293 (Pa. Super. 1997).
\item \textsuperscript{136} \textit{Woodside}, 699 A.2d at 1296 (italics added).
\item \textsuperscript{137} Interview with Kenneth Certa, M.D., \textit{supra} note 80.
\item \textsuperscript{138} \textit{Id}.
\item \textsuperscript{139} \textit{Id}.
\item \textsuperscript{140} Interview with Robin Levengood, Esq., \textit{supra} note 80.
\item \textsuperscript{141} See \textit{supra} notes 135-36 and accompanying text.
\item \textsuperscript{142} Interview with Kenneth Certa, M.D., \textit{supra} note 80.
\item \textsuperscript{143} See \textit{supra} notes 128-134 and accompanying text.
\item \textsuperscript{144} Interview with Robin Levengood, Esq., \textit{supra} note 80.
\item \textsuperscript{145} \textit{Id}.
\item \textsuperscript{146} \textit{Id}.
\item \textsuperscript{147} Interview with Kenneth Certa, M.D., \textit{supra} note 80.
\end{itemize}
According to a prominent Philadelphia psychiatrist, approximately 50% of twenty-day involuntary commitments requested under section 7303 of the PMHPA (commonly referred to as "303 commitments") are denied by the review officer in Philadelphia.\textsuperscript{148} By contrast, a review officer for rural Berks County estimates that 98% of 303 commitments are approved.\textsuperscript{149} Data from the Berks County Office of Mental Health and Mental Retardation (Berks MHMR) supports this estimate. In the three month period from July to September 1997, all thirty-five 303 petitions were approved.\textsuperscript{150}

The disparity between commitment standards in urban and rural settings may be even greater than indicated by this data. Philadelphia psychiatrists, knowing the stringent dangerousness standard required for approval of a 303 commitment, sometimes will not pursue a 303 commitment after an initial five-day period of emergency involuntary hospitalization under Section 7302 (a "302 commitment").\textsuperscript{151} While the psychiatrist may believe that further hospitalization is needed because of risk of harm to the patient or others, she may decide that the minimal chance of the review officer sustaining the commitment simply fails to justify the cost and time necessary to file a 303 commitment.\textsuperscript{152}

The plain language of the PMHPA indicates that Judge Beck's reading of the statute in \textit{Helms} is correct. The statute allows courts the discretion to use other means beyond requiring both threats and acts in furtherance of threats to determine clear and present danger. The obvious problem with rigidly requiring both threats and acts is that sometimes a mentally ill individual comes to the attention of the mental health system after making a clear statement showing suicidal or homicidal intent, but before taking any steps to put the plan into effect. Denying a petition for involuntary commitment in such situations without inquiring into the seriousness of the intent has potentially tragic consequences. The need for greater flexibility has been recognized even in Philadelphia, where the interpretation of the dangerousness standard has become somewhat less stringent in recent years.\textsuperscript{153}

\textsuperscript{148} Id.

\textsuperscript{149} Interview with Robin Levengood, Esq., \textit{supra} note 80.

\textsuperscript{150} Emergency Services Statistics, Berks County Mental Health/Mental Retardation Program (on file with author).

\textsuperscript{151} Interview with Kenneth Certa, M.D., \textit{supra} note 80.

\textsuperscript{152} Id.

\textsuperscript{153} Id.
The percentage of approved 303 commitments, while still much lower than in rural counties, has increased significantly.\textsuperscript{1} Thus the application of the clear and present danger standard, while still far from uniform, is gradually becoming more consistent.

III. CONCLUSION

The PMHPA establishes severe mental illness plus the clear and present danger of harm to oneself or others as a result of this mental illness as the requisite for involuntary commitment. The Act thus is similar to most modern involuntary commitment statutes in that mental illness and a need for treatment are no longer enough to justify the "massive curtailment of liberty" entailed by involuntary commitment.\textsuperscript{155}

Pennsylvania case law indicates, however, that courts have difficulty interpreting the PMHPA. This difficulty results from the statute's failure to define "severe mental illness" except by the exclusion of several conditions, and from the vagueness of the clear and present danger standard.

The PMHPA's exclusion of "senility" and alcohol and drug dependence from the definition of mental illness is confusing and does not comport with current understanding of these conditions. In the absence of a specific definition of mental illness, the legislature could improve the PMHPA by simply removing these exclusions. Mental illness should not be defined by the legislature's outmoded understanding of mental illness from twenty-three years ago.

The clear and present danger standard should be interpreted by courts and by mental health review officers around the state according to the plain meaning of the statute. Threats of harm to oneself or others, and acts in furtherance of these threats, may be used to show clear and present danger, but should not be mandatory. The legislature, as indicated by the PMHPA's language, intended to grant courts the necessary discretion to balance individuals' rights and the needs of society, in reaching reasonable determinations of dangerousness in complex situations. Such a reading of the statute would ultimately lead to greater consistency in the application of the PMHPA, to the benefit of patients like Maxwell Edison and his family.

\textsuperscript{154} Id.

\textsuperscript{155} Reisner, supra note 10, at 601.