MENTAL HEALTH AND JUVENILE INSTITUTIONS STUDY COMMITTEE

SUBCOMMITTEE ON COMMITMENT LAWS

Report to the Legislative Council
and the Members of the
First Session of the Sixty-sixth General Assembly

State of Iowa
1975

FINAL REPORT

OF THE MENTAL HEALTH AND JUVENILE INSTITUTIONS STUDY COMMITTEE

submitted by its

SUBCOMMITTEE ON COMMITMENT LAWS

This supplementary report consists primarily of the text of Mental Health and Juvenile Institutions Study Committee Draft Bill No. 6, fourth version, "A Bill for An Act relating to hospitalization of the mentally ill," with a number of interspersed explanatory comments. Because this format makes the draft bill somewhat bulky, and because there is interest in this bill on the part of many persons less intensely interested in other bills recommended by the Study Committee, the draft bill and three pertinent appendices are here presented with brief introductory comments separately from the main report of the Study Committee.

The Mental Health and Juvenile Institutions Study Committee's concern about Iowa's commitment laws began in 1971, the year the Study Committee was first established. In 1973, the Study Committee established the Subcommittee on Commitment Laws composed of Senator John Murray, Chairman, Representative Scott Newhard and Mr. Keith Oswald, an advisory member of the Study Committee. The Subcommittee was aware that a Joint Subcommittee of the Iowa Medical Society and the Iowa State Bar Association had been working for some time on possible revisions in the state's mental health commitment statutes. The present members of this interprofessional Joint Subcommittee are Doctors S. M. Korson of Independence, Herbert L. Nelson of Iowa City and Richard E. Preston of Des Moines, and Attorneys Randall Bezanson of Iowa City, Lee Blum of Hampton, J. Eric Heintz of Iowa City and Thomas J. Wilkinson, Jr. of Cedar Rapids.

Dr. Korson and Mr. Wilkinson attended the legislative Subcommittee's first meeting on September 6, 1973, at which time it was agreed that the Joint Subcommittee would make the product of its efforts up to that time available to the legislative Subcommittee as a starting point for the latter group in preparation of a proposed new mental health commitment statute to be reported to the full Study Committee. The legislative Subcommittee has continued to maintain liaison with the Joint Subcommittee, has made a number of changes in the text of the draft bill in response to suggestions by the Joint Subcommittee, and is most appreciative of the assistance and suggestions which have thus been made available. However, it should be understood by all concerned that the legislative Subcommittee has final responsibility for the content of the fourth version of Draft Bill No. 6, which is not necessarily satisfactory in all respects to all members of the Joint Subcommittee.

Concern about the adequacy of Iowa's present commitment laws first arose, within the Study Committee, in connection with uncertainty about the legal effect of involuntary hospitalization for reasons of mental illness upon the hospitalized individual's subsequent legal competency, status as a voter, etc.* Within the past eighteen months, however, concern has increasingly shifted to the question whether Iowa's current statute would survive a constitutional challenge in the federal courts. Generally similar laws in several other jurisdictions have been found unconstitutional on the ground that they operate to deprive the committed person ob liberty without due process of law. A commentary on the relevant constitutional issues written by Mr. Bezanson--a Univerity of Iowa College of Law faculty member--appears as Appendix I to this supplementary report.

Development of Draft Bill No. 6 began in the fall of 1973, and continued during the early months of the 1974 legislative session, as rapidly as other demands on staff time would permit. A hearing on the second version of the Draft Bill occurred March 14 under the sponsorship of the Senate Human Resources Committee.

In succeeding months, the Subcommittee revised the Draft Bill on the basis of comments received at the March 14 hearing. The third version of Draft Bill No. 6 was completed and distributed in early October, and a public hearing was held on it by the legislative Subcommittee on October 25 in Des Moines. In addition, members of both the legislative Subcommittee and the Joint Subcommittee participated in panel discussions of the draft bill at sessions arranged by the Iowa District Court Clerks Association and the Iowa Psychiatric Society, and copies of the third version were distributed widely to a large number of interested parties throughout the state.

The final meetings of the legislative Subcommittee were held December 3 and December 12, to consider the various comments and suggestions which had been received on the third version of Draft Bill No. 6. Pursuant to actions taken at those two meetings, a fourth version of the Draft Bill has been prepared and is by this report submitted to the 66th General Assembly for its consideration. The Draft Bill is designated "fourth version" rather than final version because the necessary conforming amendments have not yet been completed, and because it is recognized that the bill remains controversial and that the standing committees to which the bill will presumably be referred will wish to give further consideration to some of the major policy questions involved. Nevertheless, Draft Bill No. 4 represents the Subcommittee's judgment as to the policies the state should adopt in this area of law, and the full Study Committee on November 20 authorized the Subcommittee to submit the draft bill to the General Assembly on that basis.

Role of the District Court

One of the questions raised by court decisions in other jurisdictions regarding commitment of mentally ill persons for treatment is whether involuntary hospitalization (viewed as a deprivation of liberty) can constitutionally be done by any agency except a court. Concern about this question led the interprofessional Joint Subcommittee, in its early efforts, and subsequently the legislative Subcommittee to draw Draft Bill No. 6 on the basis of direct handling of commitment proceedings by judges of the district court rather than by the three-member hospitalization commissions which now exist in each county.

Initial reaction to this type of procedure, particularly by county district court clerks, was that it is essentially unworkable because in many smaller counties there is insufficient access to a district court judge to allow prompt handling of hospitalization proceedings. Therefore, the Subcommittee placed in the third version of Draft Bill No. 6 a section which:

- Authorizes the judges in each judicial district to jointly establish, as an arm of the court, a judicial hospitalization commission to perform most of the functions of the district court in hospitalization matters in any county where the judges consider it advisable to exercise this option.

- Makes the judicial hospitalization commission generally similar in makeup to the existing county commissions of hospitalization, except that the clerk of court would provide staff assistance rather than serving as a member of the commission and the third commission member would be a knowledgeable layman.

- Requires the judicial hospitalization commission to follow all substantive procedures specified in the bill for the courts, makes the commission's actions subject to appeal to the district courts, and allows only district court judges to issue orders for immediate custody of a respondent pending a hospitalization hearing.

The Joint Subcommittee, on reviewing the third version of Draft Bill No. 6, expressed the view that the use of a judicial hospitalization commission would be unconstitutional. Also, the legislative Subcommittee received a letter from the County Officers Coordinating Committee expressing opposition to Draft Bill No. 6 in its entirety, but also asserting that if the present Iowa commission of hospitalization statute is unconstitutional then the proposed judicial hospitalization commission would be equally so. The letter appears as Appendix II to this supplementary report.

While the legislative Subcommittee's members do not necessarily agree with these views, they decided upon review of the objections that the judicial hospitalization commission option

should be removed from the fourth version of Draft Bill No. 6. There appears to be little reason to retain in the bill such a provision when virtually no support for it has been expressed outside the membership of the legislative Subcommittee. However, for the information of legislators and others who may have occasion to contemplate the mechanics of implementing Draft Bill No. 6 should it be enacted, the judicial hospitalization commission section from the third version of the Draft Bill appears as Appendix III to this supplementary report.

Draft Bill No. 6, Fourth Version-- Text and Explanatory Comments

The text of Draft Bill No. 6, fourth version, and of the explanatory comments interspersed therein, constitute the balance of this supplementary report.

Mental Health and Juvenile Institutions Study Committee, Subcommittee on Commitment Laws
Draft Bill No. 6 - Fourth Version

December, 1974

Passed Senate, Date_____ Passed House, Date_____

Vote: Ayes_____ Nays_____ Vote: Ayes_____ Nays_____

Approved_____

A BILL FOR

An Act relating to hospitalization of the mentally ill.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

CPB-16191 12/72

S.F. _____ H.F. _____

Section 1. NEW SECTION. DEFINITIONS. As used in this Act, unless the context clearly requires otherwise:

1. "Mental illness" means every type of mental disease or mental disorder, except that it does not refer to mental retardation as defined in section two hundred twenty-two point two (222.2), subsection five (5) of the Code.

2. "Seriously mentally impaired" or "serious mental impairment" describes the condition of a person who is afflicted with mental illness and because of that 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 family or others who lack reasonable opportunity to avoid contact with the afflicted person if the afflicted person is allowed to remain at liberty without treatment.

3. "Serious emotional injury" is an injury which does not necessarily exhibit any physical characteristics, but which can be recognized and diagnosed by a medical practitioner and which can be causally connected with the act or omission of a person who is, or is alleged to be, mentally ill.

COMMENT: The three foregoing definitions are crucial to the central issue of who may be involuntarily hospitalized by reason of mental illness.

One of the points often made in court decisions involving commitment statutes of other jurisdictions is that the legal definition of mental illness is overly broad or vague. Yet, mental illness is a term that is quite difficult to define with the precision that is necessary or desirable in describing a condition on the basis of which one may be deprived of liberty by involuntary hospitalization. In this draft bill, an attempt is made

to evade the problem by retaining a broad definition of the concept of mental illness, while defining more narrowly that kind or degree of mental illness which justifies deprivation of liberty.

The definition of mental illness in subsection 1 is basically that now found in section 229.40 of the Code, except that the present definition does not specifically exclude mental retardation. (However, section 226.8 does bar admission of a mentally retarded person to state mental health institutes unless a professional diagnostic evaluation indicates the admission is appropriate for that particular individual.) Involuntary hospitalization may occur under this draft bill if it appears that the prospective patient is "seriously mentally impaired", i.e., so mentally ill that he or she (1) lacks ability to make responsible decisions about hospitalization or treatment, and (2) is also likely to physically injure himself or herself or others, or to inflict serious emotional injury on other persons.

It is recognized that the concept and the definition of "serious emotional injury" is controversial. It represents a search for a middle ground between those who have argued that involuntary hospitalization should occur only when the prospect of physical injury to the prospective patient himself or herself, or to other persons, can be shown (or when this has actually occurred), and the urging of mental health professionals that some situations which do not involve any threat of physical injury are nevertheless so serious that society is justified in compelling the mentally ill person to accept treatment. Some possible examples of "serious emotional injury" might be a disturbed parent who poses no threat of physical injury to anyone, but persists in directing paranoid statements and epithets at spouse and children, or a person who in manic euphoria makes unrealistic expenditures or

financial commitments that threaten to impoverish his or her family.

4. "Respondent" means any person against whom an application has been filed under section six (6) of this Act, but who has not been finally ordered committed for full-time custody, care and treatment in a hospital.

5. "Patient" means a person who has been hospitalized or ordered hospitalized to receive treatment pursuant to section fourteen (14) of this Act.

6. "Licensed physician" means an individual licensed under the provisions of chapter one hundred forty-eight (148) of the Code to practice medicine (, or a medical officer of the government of the United States while in this state in the performance of his official duties).

7. "Qualified mental health professional" means an individual experienced in the study and treatment of mental disorders in the capacity of:

a. A psychologist certified under chapter one hundred fifty-four B (154B) of the Code; or

b. A registered nurse licensed under chapter one hundred fifty-two (152) of the Code; or

c. A social worker who holds a masters degree in social work awarded by an accredited college or university.

COMMENT: The definition of "qualified mental health professional" is included in order to provide a groundwork for utilizing the expertise or information which these persons may be able to contribute to the disposition of some proceedings in which it is alleged that an individual is seriously mentally impaired. It is NOT intended that a "qualified mental health professional" should in any case supplant a licensed physician in the procedure prescribed by this draft bill, but rather that the qualified professional be given standing to serve as an additional

resource. See section 10 of this draft bill.

8. "Public hospital" means:

a. A state mental health institute established by chapter two hundred twenty-six (226) of the Code; or

b. The state psychopathic hospital established by chapter two hundred twenty-five (225) of the Code; or

c. Any other publicly supported hospital or institution, or part thereof, which is equipped and staffed to provide inpatient care to the mentally ill, except that this definition shall not be applicable to the Iowa security medical facility established by chapter two hundred twenty-three (223) of the Code.

9. "Private hospital" means any hospital or institution not directly supported by public funds, or a part thereof, which is equipped and staffed to provide inpatient care to the mentally ill.

10. "Hospital" means either a public hospital or a private hospital.

11. "Chief medical officer" means the medical director in charge of any public hospital, or any private hospital, or that individual's physician-designee. Nothing in this Act shall negate the authority otherwise reposed by law in the respective superintendents of each of the state hospitals for the mentally ill, established by chapter two hundred twenty-six (226) of the Code, to make decisions regarding the appropriateness of admissions or discharges of patients of that hospital, however it is the intent of this Act that if the superintendent is not a licensed physician he shall be guided in these decisions by the chief medical officer of that hospital.

COMMENT: The second sentence of the foregoing definition has been added at the request of the Department of Social Services, which was concerned about the import

of the definition of a "chief medical officer", and the role assigned that individual under this draft bill, where a state mental health institute has a nonphysician superintendent, as permitted by section 226.2.

12. "Clerk" means the clerk of the district court.

Sec. 2. NEW SECTION. APPLICATION FOR VOLUNTARY ADMISSION--AUTHORITY TO RECEIVE VOLUNTARY PATIENTS.

1. An application for the admission of any person who is mentally ill or has symptoms of mental illness to a public or private hospital for observation, diagnosis, care and treatment as a voluntary patient may be made by:

a. The person seeking admission if he is eighteen years of age or older; or

b. The parent or legal guardian of the person whose admission is sought, if the person is under eighteen years of age.

2. Upon receiving an application for admission as a voluntary patient, made pursuant to subsection one (1) of this section:

a. The chief medical officer of a public hospital shall receive and may admit the person whose admission is sought, subject in cases other than medical emergencies to availability of suitable accommodations and to the provisions of section _____ of this Act.

b. The chief medical officer of a private hospital may receive and may admit the person whose admission is sought.

COMMENT: There has been some objection to the inclusion of section 2 in the draft bill, on the ground that there is no need for the law to regulate the furnishing of hospital services to mentally ill persons on a voluntary basis in any different manner than is the case with persons having other kinds of illnesses.

Concern has been expressed that this section as

previously written could give nonresidents access to Iowa's mental health institutes on the same basis as Iowans. The reference to an unspecified section of this Act will be used to tie into this bill present law regarding the financial basis on which admissions are made, and related matters.

Sec. 3. NEW SECTION. DISCHARGE OF VOLUNTARY PATIENTS. Any voluntary patient who has recovered, or whose hospitalization the chief medical officer of the hospital determines is no longer advisable, shall be discharged. Any voluntary patient may be discharged if to do so would in the judgment of the chief medical officer contribute to the most effective use of the hospital in the care and treatment of that patient and of other mentally ill persons.

Sec. 4. NEW SECTION. RIGHT TO RELEASE ON APPLICATION. A voluntary patient who requests his or her release or whose release is requested, in writing, by his legal guardian, parent, spouse or adult next-of-kin shall be released from the hospital forthwith, except that:

1. If the patient was admitted on his own application and the request for release is made by some other person, release may be conditioned upon the agreement of the patient; and

2. If the patient, by reason of his or her age, was admitted on the application of another person pursuant to section two (2), subsection one (1), paragraph b of this Act, his or her release prior to becoming eighteen years of age may be conditioned upon the consent of his or her parent or guardian, or upon the approval of the juvenile court; and

3. If the chief medical officer of the hospital, not later than the end of the next secular day on which the office of the clerk of the district court for the county in which the hospital is located is open and which follows the submission of the written request for release of the patient, files with

that clerk a certification that in the chief medical officer's opinion the patient is seriously mentally impaired, the release may be postponed for the period of time the court determines is necessary to permit commencement of judicial procedure for involuntary hospitalization. That period of time may not exceed five days, exclusive of days on which the clerk's office is not open. Until disposition of the application for involuntary hospitalization of the patient, if one is timely filed, the chief medical officer may detain the patient in the hospital and may provide treatment which is necessary to preserve his or her life, or to appropriately control behavior by the patient which is likely to result in physical injury to himself or herself or to others if allowed to continue, but may not otherwise provide treatment to the patient without the patient's consent.

COMMENT: In an earlier version of this draft bill, section 4 also included a subsection prohibiting commitment procedure against any voluntary patient whose release has not been requested. That subsection was deleted on advice of the Department of Social Services that voluntary patients must occasionally be committed for nonmedical reasons, usually in connection with a transfer to another state or to a facility such as a county home. Some objections to this deletion have been expressed.

Sec. 5. NEW SECTION. DEPARTURE WITHOUT NOTICE. If a voluntary patient departs from the hospital without notice, and in the opinion of the chief medical officer the patient is seriously mentally impaired, the chief medical officer may file an application for involuntary hospitalization of the departed voluntary patient, and request that an order for immediate custody be entered by the court pursuant to section eleven (11) of this Act.

COMMENT: A suggestion has been advanced that section 5 be expanded to include a specific statement that where a voluntary patient departs from the hospital without notice, and that patient is not considered dangerous, the hospital is relieved of any further responsibility for that patient. The Subcommittee felt that such a provision would have implications that should be carefully considered before a decision is made to include it in the bill, and there was no opportunity to adequately consider the question before reporting this Draft Bill to the General Assembly.

Sec. 6. NEW SECTION. APPLICATION FOR ORDER OF INVOLUNTARY HOSPITALIZATION. Proceedings for the involuntary hospitalization of an individual may be commenced by any interested person by filing a verified application with the clerk of the district court of the county where the respondent is presently located. The clerk, or his or her designee, shall assist the applicant in completing the application. The application shall:

1. State the applicant's belief that the respondent is seriously mentally impaired.

2. State any other pertinent facts.

3. Be accompanied by:

a. A written statement of a licensed physician in support of the application; or

b. One or more supporting affidavits otherwise corroborating the application; or

c. Corroborative information obtained and reduced to writing by the clerk or his or her designee, but only when circumstances make it infeasible to comply with, or when the clerk considers it appropriate to supplement the information supplied pursuant to, either paragraph a or paragraph b of this subsection.

COMMENT: Some concern has been expressed about use

of the term "verified application" in the first sentence of section 6. The requirement of a verified application serves to help impress upon the applicant the seriousness of the step being taken, and perhaps to affirm the applicant's good faith, by making it necessary for the applicant to sign under oath a statement that he or she "verily believes" that all statements made in the application are true. The fact that an application is so verified does not create any presumption that the applicant is correct in believing that the respondent is mentally ill.

There has also apparently been some concern that subsection 3 equates the "supporting affidavits" referred to in paragraph b with a physician's statement. However, the intent is to provide for those situations where the perceived need for hospitalization of the respondent is quite pressing, and for some reason a physician's written statement cannot be expeditiously obtained. In evaluating this provision, it must be kept in mind that the emergency hospitalization procedure provided by section 18 is specifically limited to situations where there is no means of immediate access to the district court.

For similar reasons, the Medical Society-Bar Association Joint Subcommittee suggested and the legislative Subcommittee agreed to add to the Draft Bill the provision which appears as paragraph c of subsection 3 of section 6.

Sec. 7. NEW SECTION. SERVICE OF NOTICE UPON RESPONDENT. Upon the filing of an application for involuntary hospitalization, the clerk shall docket the case and immediately notify a district court judge who shall review the application and accompanying documentation. If the application is adequate as to form, the judge shall direct the clerk to send copies of the application and supporting

documentation, together with a notice informing the respondent of the procedures required by this Act, to the sheriff or his or her deputy for immediate service upon the respondent. If the respondent is taken into custody under section eleven (11) of this Act, service of the application, documentation and notice upon the respondent shall be made at the time he or she is taken into custody.

Sec. 8. NEW SECTION. PROCEDURE AFTER APPLICATION IS FILED. As soon as practicable after the filing of an application for involuntary hospitalization, the court shall:

1. Determine whether the respondent has an attorney who is able and willing to represent him or her in the hospitalization proceeding, and if not, whether the respondent is financially able to employ an attorney and capable of meaningfully assisting in selecting one. In accordance with those determinations, the court shall if necessary allow the respondent to select, or shall assign to him or her, an attorney. If the respondent is financially unable to pay an attorney, the attorney shall be compensated in substantially the manner provided by sections seven hundred seventy-five point five (775.5) and seven hundred seventy-five point six (775.6) of the Code, except that if the county has a public defender the court may designate the public defender or an attorney on his or her staff to act as the respondent's attorney.

2. Cause copies of the application and supporting documentation to be sent as soon as practicable to the county attorney or his or her attorney-designate for review.

3. Issue a written order which shall:

a. Set a time and place for a hospitalization hearing, which shall be at the earliest practicable time; and

b. Order an examination of the respondent, prior to the hearing, by one or more licensed physicians who shall submit a written report on the examination to the court as required by section ten (10) of this Act.

COMMENT: The sequence of the provisions within this section is intended to emphasize the requirement that the respondent have the assistance of counsel at the earliest feasible time in the involuntary hospitalization proceeding. Subsection 2 reflects the requirement of section 12 that the county attorney or his designee present the case for the applicant at the hospitalization hearing.

The sequence of sections 7 and 8 were reversed from that of earlier versions of this draft bill because it appeared inappropriate to try to determine whether the respondent has an attorney, or is able to help select one, until notice of the proceeding has been served on the respondent.

Sec. 9. NEW SECTION. DUTIES OF RESPONDENT'S ATTORNEY. The court shall direct the clerk to furnish at once to the respondent's attorney copies of the application for involuntary hospitalization of the respondent and the supporting documentation, and of the court's order issued pursuant to section eight (8), subsection three (3) of this Act. If the respondent is taken into custody under section eleven (11) of this Act, the attorney shall also be advised of that fact. The respondent's attorney shall attend the hospitalization hearing.

Sec. 10. NEW SECTION. PHYSICIANS' EXAMINATION--REPORT.

1. An examination of the respondent shall be conducted by one or more licensed physicians, as required by the court's order, within a reasonable time. If the respondent is taken into custody under section eleven (11) of this Act, the examination shall be conducted within twenty-four hours. If the respondent so desires, he or she shall be entitled to a separate examination by a licensed physician of his or her own choice. The reasonable cost of such separate examination shall, if the respondent lacks sufficient funds to pay

the cost, be paid from county funds upon order of the court.

Any licensed physician conducting an examination pursuant to this section may consult with or request the participation in the examination of any qualified mental health professional, and may include with or attach to the written report of the examination any findings or observations by any qualified mental health professional who has been so consulted or has so participated in the examination.

2. A written report of the examination by the court-designated physician or physicians, and of any examination by a physician chosen by the respondent, shall be filed with the clerk prior to the hearing date. The clerk shall immediately:

a. Cause the report or reports to be shown to the judge who issued the order; and

b. Cause the respondent's attorney to receive a copy of each report filed.

3. If the report of the court-designated physician or physicians is to the effect that the individual is not seriously mentally impaired, the court may without taking further action terminate the proceeding and dismiss the application on its own motion and without notice.

4. If the report of the court-designated physician or physicians is to the effect that the respondent is seriously mentally impaired, the court shall schedule a hearing on the application as soon as possible. The hearing shall be held not more than forty-eight hours after the report is filed, excluding Saturdays, Sundays and holidays, unless an extension is requested by the respondent, or as soon thereafter as possible if the court considers that sufficient grounds exist for delaying the hearing.

COMMENT: The provision for participation of qualified mental health professionals in the examination or evaluation of a respondent in an involuntary hospitalization

proceeding, appearing in subsection 1 of section 10, was added by the Subcommittee in response to the suggestion of a clinical psychologist, who felt that such persons (as defined in section 1, subsection 7) might well be able to make a contribution to the procedure.. Participation of qualified mental health professionals is at the option of the physician because representatives of the medical profession expressed concern that the other professionals might otherwise supplant, rather than supplement, the work of the physician, particularly in areas where psychiatrists are not readily accessible.

Sec. 11. NEW SECTION. JUDGE MAY ORDER IMMEDIATE CUSTODY. If the applicant requests that the respondent be taken into immediate custody and the judge, upon reviewing the application and accompanying documentation, finds probable cause to believe that the respondent is seriously mentally impaired and concludes that immediate custody is appropriate, the judge may enter a written order directing that the respondent be taken into immediate custody by the sheriff or his or her deputy and be detained until the hospitalization hearing, which shall be held no more than five days after the date of the order. The judge may order the respondent detained for that period of time, and no longer, as follows:

1. In a suitable hospital the chief medical officer of which may provide treatment which is necessary to preserve the respondent's life, or to appropriately control behavior by the respondent which is likely to result in physical injury to himself or herself or to others if allowed to continue, but may not otherwise provide treatment to the respondent without the respondent's consent; or

2. In a public or private facility in the community which is suitably equipped and staffed for the purpose, provided that detention in a jail or other facility intended for confinement of those accused or convicted of crime may not

be ordered except in cases of actual emergency and then only for a period of not more than twenty-four hours and under close supervision; or

3. In the custody of a relative, friend or other suitable person who is willing to accept responsibility for supervision of the respondent, and the respondent may be placed under such reasonable restrictions as the judge may order including, but not limited to, restrictions on or a prohibition of any expenditure, encumbrance or disposition of the respondent's funds or property.

COMMENT: The second sentence of section 11, and subsections 1, 2, and 3, were drawn in response to various comments received regarding section 11 of an earlier version of this draft, which provided for persons taken into custody and awaiting a hospitalization hearing to be held in "a medical detention facility". The intent at the time was to subsequently define "medical detention facility" in some appropriate manner, but it appears that circumstances in different parts of the state vary so much that any attempt to write a descriptive definition would probably, in fact, become substantive legislation. That being the case, section 11 instead specifies the places and conditions in which detention may be ordered.

Note that the term "hospital", used in subsection 1 of section 11, is defined in section 1, subsection 10 of the bill.

Sec. 12. NEW SECTION. HEARING PROCEDURE. At the hospitalization hearing, evidence in support of the contentions made in the application shall be presented by the county attorney. During the hearing the applicant and the respondent shall be afforded an opportunity to testify and to present and cross-examine witnesses, and the court may receive the testimony of any other interested person. The respondent

has the right to be present at the hearing. All persons not necessary for the conduct of the proceeding shall be excluded, except that the court may admit persons having a legitimate interest in the proceeding. The respondent's welfare shall be paramount and the hearing shall be conducted in as informal a manner as may be consistent with orderly procedure, but consistent therewith the issue shall be tried as a civil matter. Such discovery as is permitted under the Iowa rules of civil procedure shall be available to the respondent. The court shall receive all relevant and material evidence which may be offered and need not be bound by the rules of evidence. There shall be a presumption in favor of the respondent, and the burden of evidence in support of the contentions made in the application shall be upon the applicant. If upon completion of the hearing the court finds that the contention that the respondent is seriously mentally impaired has not been sustained by clear and convincing evidence, it shall deny the application and terminate the proceeding.

Sec. 13. NEW SECTION. HOSPITALIZATION FOR EVALUATION. If upon completion of the hearing the court finds that the contention that the respondent is seriously mentally impaired has been sustained by clear and convincing evidence, it shall order the respondent placed in a hospital as expeditiously as possible for a complete psychiatric evaluation and appropriate treatment. The court shall furnish to the hospital a written finding of fact setting forth the evidence on which the finding is based. The chief medical officer of the hospital shall report to the court no more than fifteen days after the individual is admitted to the hospital, making a recommendation for disposition of the matter. An extension of time may be granted for not to exceed seven days upon a showing of cause. A copy of the report shall be sent to the respondent's attorney, who may contest the need for an extension of time if one is requested. Extension of time

shall be granted upon request unless the request is contested, in which case the court shall make such inquiry as it deems appropriate and may either order the respondent's release from the hospital or grant extension of time for psychiatric evaluation.

COMMENT: It was suggested at the March 14, 1974 public hearing on the second version of this draft bill that, as some people "are skilled at dissembling, either good or bad," a psychiatric evaluation of less than 15 to 30 days is likely to prove insufficient. However, those whose concern about involuntary hospitalization procedures is oriented toward civil and procedural rights tend to view any prolonged period of hospitalization without court review as at least undesirable, if not unconstitutional. Section 13 attempts to reach a compromise between these viewpoints by providing for both an initial fifteen-day period for psychiatric evaluation, and a seven-day extension when the chief medical officer of the hospital so requests. An extension for an additional seven days, beyond the original fifteen-day period, would bring the total period of evaluation well within the range suggested above. The respondent's attorney is notified if an extension is requested, and has the opportunity to oppose the request if he or she considers it unwarranted.

Sec. 14. NEW SECTION. CHIEF MEDICAL OFFICER'S REPORT. The chief medical officer's report to the court on the psychiatric evaluation of the respondent shall be made not later than the expiration of the time specified in section thirteen (13) of this Act. At least two copies of the report shall be filed with the clerk, who shall dispose of them in the manner prescribed by section ten (10), subsection two (2) of this Act. The report shall state one of the four following alternative findings:

1. That the respondent does not, as of the date of the report, require further treatment for serious mental impairment. If the report so states, the court shall order the respondent's immediate release from involuntary hospitalization and terminate the proceedings.

2. That the respondent is seriously mentally ill and in need of full-time custody, care and treatment in a hospital. If the report so states, the court shall order the respondent's continued hospitalization for appropriate treatment.

3. That the respondent is seriously mentally ill and in need of full-time custody and care, but is unlikely to benefit from further treatment in a hospital. If the report so states, the chief medical officer shall recommend an alternative placement for the respondent and the court may order the respondent's transfer to the recommended placement. If the court or the respondent's attorney consider the placement inappropriate, an alternative placement may be arranged upon consultation with the chief medical officer and approval of the court.

COMMENT: Included in section 15 of the previous version of this draft bill was a provision representing a major change in the philosophy both of the draft bill and of present Iowa law, i.e. the introduction of the concept that a person may be ordered by the court to receive treatment for mental illness on some basis other than full-time hospitalization. Refusal to receive such treatment as ordered would have resulted in the person involved being placed in full-time hospital care. While this presumably would create some incentive for the person involved to cooperate in the court-ordered treatment program, the provision was not basically intended as a sanction. Rather, it was a recognition that the person involved would have been found seriously mentally impaired, as defined in section 1 of this draft bill, and that the welfare of

society requires his or her treatment for this condition. If the person involved refused to cooperate on any other basis, full-time hospitalization would be the only alternative to allowing him or her to remain untreated.

The provision for court-ordered involuntary treatment was removed from this version of the bill by the legislative Subcommittee, somewhat reluctantly, in response both to apparently unanimous opposition by the medical profession (on grounds that the concept is self-contradictory because out-patient mental treatment can succeed only if it is truly voluntary on the part of the patient), and to some expressions of concern on constitutional grounds by attorneys.

Sec. 15. NEW SECTION. PERIODIC REPORTS REQUIRED.

1. Not more than thirty days after entry of an order for continued hospitalization of a patient under subsection two (2) of section fourteen (14) of this Act, and thereafter at successive intervals of not more than sixty days continuing so long as involuntary hospitalization of the patient continues, the chief medical officer of the hospital shall report to the court which entered the order. The report shall be submitted in the manner required by section fourteen (14) of this Act, shall state whether the patient's condition has improved, remains unchanged, or has deteriorated, and shall indicate if possible the further length of time the patient will be required to remain at the hospital. The chief medical officer may at any time report to the court a finding as stated in subsection three (3) of section fourteen (14) of this Act, and the court shall act thereon as required by that section.

2. When a patient has been placed in a facility other than a hospital pursuant to section fourteen (14), subsection three (3) of this Act, a report on the patient's condition and prognosis shall be made to the court which so placed the

patient, at least once every six months. The report shall be submitted within fifteen days following the inspection, required by section two hundred twenty-seven point two (227.2) of the Code, of the facility in which the patient has been placed.

3. When in the opinion of the chief medical officer the best interest of a patient would be served by transfer to a different hospital for continued full-time custody, care and treatment, the chief medical officer may arrange and complete the transfer but shall promptly report the transfer to the court. Nothing in this section shall be construed to add to or restrict the authority otherwise provided by law for transfer of patients or residents among various state institutions administered by the department of social services.

4. Upon receipt of any report required or authorized by this section the court shall furnish a copy to the patient's attorney, or alternatively to the advocate appointed as required by section seventeen (17) of this Act. The court shall examine the report and take the action thereon which it deems appropriate.

COMMENT: The purpose of section 15 is to insure that the court is advised of and has the opportunity to oversee the treatment of the patient to the extent necessary to insure that the patient's constitutional rights are protected, and thereby meet the procedural requirements indicated by various court decisions in recent months and years. It is recognized that this section will impose duties on courts and judges which could prove burdensome--see section 17 of this draft bill.

The question has been raised whether it would be possible under this draft bill for an involuntary patient who wished to do so to become a voluntary patient. It is believed that the chief medical officer would have latitude to report this fact to the court, which could

take appropriate action. However, there is no specific statement to that effect in the draft bill.

Sec. 16. NEW SECTION. DISCHARGE AND TERMINATION OF PROCEEDING. When in the opinion of the chief medical officer a patient who is hospitalized under subsection two (2) or is in full-time care and custody under subsection three (3) of section fourteen (14) of this Act no longer requires treatment or care for serious mental impairment, the chief medical officer shall immediately report that fact to the court which ordered the patient's hospitalization or care and custody. The court shall thereupon issue an order discharging the patient from the hospital or from care and custody, as the case may be, and shall terminate the proceedings pursuant to which the order was issued.

COMMENT: The provisions of this section are set forth separately from section 15 to emphasize their importance and finality.

Sec. 17. NEW SECTION. ADVOCATE APPOINTED. The district court in each county shall appoint an individual who has demonstrated by prior activities an informed concern for the welfare and rehabilitation of the mentally ill, and who is not an officer or employee of the department of social services nor of any agency or facility providing care or treatment to the mentally ill, to act as advocate representing the interests of all patients involuntarily hospitalized by that court, in any matter relating to the patients' hospitalization or treatment under sections fourteen (14) or fifteen (15) of this Act. The advocate shall, wherever practical, be an attorney. The advocate's responsibility with respect to any patient shall begin at whatever time the attorney employed or appointed to represent that patient as respondent in hospitalization proceedings, conducted under sections six

(6) through thirteen (13) of this Act, reports to the court that his or her services are no longer required and requests the court's approval to withdraw as counsel for that patient. The clerk shall furnish the advocate with a copy of the court's order approving the withdrawal. The advocate's duties shall include reviewing each report submitted pursuant to sections fourteen (14) and fifteen (15) of this Act concerning any patient whose interests, as a patient, the advocate is required to represent under this section, and if the advocate is not an attorney, advising the court at any time it appears that the services of an attorney are required to properly safeguard the patient's interests. The court shall from time to time prescribe reasonable compensation for the services of the advocate. Such compensation shall be based upon reports filed by the advocate at such times and in such forms as the court shall prescribe. The report shall briefly state what the advocate has done with respect to each patient and the amount of time spent. The advocate's compensation shall be paid on order of the court from the county mental health and institutions fund of the county in which the court is located.

COMMENT: The provision for a court-appointed advocate to look after the interests of patients hospitalized or being treated under order of the court is intended to help make the reporting requirements of section 15 meaningful. It is unlikely that all attorneys who represent respondents during the legal proceedings preceding hospitalization will have the time or interest to continue following the case, particularly if the necessary treatment is at all prolonged or the attorney is appointed at public expense.

Sec. 18. NEW SECTION. HOSPITALIZATION--EMERGENCY PROCEDURE.

1. The procedure prescribed by this section shall not be used unless it appears that a person should be immediately

detained due to serious mental impairment, but that person cannot be immediately detained by the procedure prescribed in sections six (6) and eleven (11) of this Act because there is no means of immediate access to the district court.

2. In the circumstances described in subsection one (1) of this section, any peace officer who has reasonable grounds to believe that a person is mentally ill, and because of that illness is likely to physically injure himself or herself or others if not immediately detained, may without a warrant take or cause that person to be taken to the nearest available facility as defined in section eleven (11), subsections one (1) and two (2) of this Act. Immediately upon taking the person into custody, the nearest available magistrate, as defined in section seven hundred forty-eight point one (748.1) of the Code, shall be notified and shall immediately proceed to the facility. The magistrate shall in the manner prescribed by section eight (8), subsection one (1) of this Act insure that the person has or is provided legal counsel, and shall arrange for the counsel to be present, if practicable, before proceeding under this section. The peace officer who took the person into custody shall remain until the magistrate's arrival and shall describe the circumstances of the detention to the magistrate. If the magistrate finds that there is probable cause to believe that the person is seriously mentally ill, and because of that illness is likely to physically injure himself or herself or others if not immediately detained, he or she shall enter a written order for the person to be detained in custody and, if the facility where the person is at that time is not an appropriate hospital, transported to an appropriate hospital. The magistrate's order shall state the circumstances under which the person was taken into custody and the grounds supporting the finding of probable cause to believe that he or she is mentally ill and likely to physically injure himself or herself or others if not immediately detained. A certified copy of the order

shall be delivered to the chief medical officer of the hospital where the person is detained, at the earliest practicable time.

3. The chief medical officer of the hospital shall examine and may detain, care for and treat the person taken into custody under the magistrate's order for a period not to exceed forty-eight hours, excluding Saturdays, Sundays and holidays. The person shall be discharged from the hospital and released from custody not later than the expiration of that period, unless an application for his or her involuntary hospitalization is sooner filed with the clerk pursuant to section six (6) of this Act. The detention of any person by the procedure and not in excess of the period of time prescribed by this section shall not render the peace officer, physician or hospital so detaining that person liable in a criminal or civil action for false arrest or false imprisonment if the peace officer, physician or hospital had reasonable grounds to believe the person so detained was mentally ill and likely to physically injure himself or herself or others if not immediately detained.

4. The cost of hospitalization at a public hospital of a person detained temporarily by the procedure prescribed in this section shall be paid in the same way as if the person had been admitted to the hospital by the procedure prescribed in sections six (6) through thirteen (13) of this Act.

COMMENT: Section 18 is a key part of this draft bill. Iowa presently has no specific statutory procedure for handling those situations which occasionally arise late at night or on a weekend or holiday, in which an apparently mentally ill person is acting in ways which threaten harm to himself or herself, or to others, and the situation must be dealt with at once. The procedure prescribed in this section is similar in many respects to that provided by legislation submitted to the 65th General Assembly

but not acted upon. Major additions during development of this draft bill are the provisions in subsection 2 which require (1) that the magistrate immediately begin efforts to insure that the person whose hospitalization is sought has legal counsel and bring the counsel into the emergency proceeding "if practicable", and (2) that the person detained be taken directly to a hospital or other facility and that the magistrate also come there to handle the required hearing procedure. It has been suggested that the term "reasonable grounds" appearing in the first sentence in subsection 2 and the last sentence of subsection 3 should be changed to "probable cause". The legislative Subcommittee decided against this; i.e., a peace officer may take a person into custody under this section if he believes he has "reasonable grounds" to think that person is seriusly mentally impaired. It is to be noted, however, that the magistrate must release the person from custody unless there is "probable cause" to think he or she is seriously mentally impaired.

Sec. 19. NEW SECTION. RIGHTS AND PRIVILEGES OF HOSPITALIZED PERSONS. Every person who is hospitalized or detained under this Act shall have the right to:

1. Prompt evaluation, emergency psychiatric services, and care and treatment as indicated by sound medical practice.

2. In addition to protection of his constitutional rights, enjoyment of other legal, medical, religious, social, political, personal and working rights and privileges which he would enjoy if he were not so hospitalized or detained, so far as is possible consistent with effective treatment of that person and of the other patients of the hospital. The department of social services shall, in accordance with chapter seventeen A (17A) of the Code establish rules setting forth the specific rights and privileges to which persons so hospitalized or detained are entitled under this section,

and the exceptions provided by section seventeen A point two (17A.2), subsection seven (7), paragraphs a and k, shall not be applicable to the rules so established. The patient shall be advised of these rules and be provided a written copy upon admission to or arrival at the hospital.

COMMENT: Subsection 2 of section 20 has been drafted in accordance with enactment in 1974 of the new Administrative Procedure Act. (The citations in subsection 2 apply to the Code of 1975, not earlier editions.) A number of comments have been received on the provisions of subsection 2, at and after each of the public hearing on the previous versions of this draft bill. These have ranged from objections to the subsection on the ground that calling attention to a list of patients' rights will make treatment of patients in mental hospitals more difficult, to requests that the departmental rule approach be discarded in favor of spelling out all patients' rights in law.

Sec. 20. NEW SECTION. RECORDS OF INVOLUNTARY HOSPITALIZATION PROCEEDING TO BE CONFIDENTIAL.

1. All papers and records pertaining to any involuntary hospitalization or application for involuntary hospitalization of any person under this Act, whether part of the permanent record of the court or of a file in the department of social services, are subject to inspection only upon an order of the court for good cause shown.

2. If authorized in writing by a person who has been the subject of any proceeding or report under sections six (6) through thirteen (13) or section eighteen (18) of this Act, or by the parent or guardian of that person, information regarding that person which is confidential under subsection one (1) of this section may be released to any designated person.

Sec. 21. NEW SECTION. MEDICAL RECORDS TO BE CONFIDENTIAL--EXCEPTIONS. The records maintained by a hospital relating to the examination, custody, care and treatment of any person in that hospital pursuant to this Act shall be confidential, except that the chief medical officer may release appropriate information when:

1. The information is requested by a licensed physician who provides the chief medical officer with a written waiver signed by the person about whom the information is sought; or

2. The information is sought by a court order; or

3. The information is requested for the purpose of research into the causes, incidence, nature and treatment of mental illness. Information provided under this subsection shall not be published in a way that discloses patients' names or other identifying information.

Sec. 22. NEW SECTION. EXCLUSIVE PROCEDURE FOR INVOLUNTARY HOSPITALIZATION. Sections six (6) through (15), inclusive, of this Act shall constitute the exclusive procedure for involuntary hospitalization of persons by reason of serious mental impairment in this state, except that nothing in this Act shall negate the provisions of sections two hundred forty-five point twelve (245.12) and two hundred forty-six point sixteen (246.16) of the Code relative to transfer of mentally ill prisoners to state hospitals for the mentally ill.

COMMENT: As presently worded, section 22 may be too far-reaching. A final decision on the provisions of this section should be made only when the scope of this draft bill has been decided upon. For example, a question has been raised as to whether this section would create a conflict with the criminal sexual psychopath law.

Sec. 23. NEW SECTION. HOSPITALIZATION NOT TO EQUATE WITH INCOMPETENCY--PROCEDURE FOR FINDING INCOMPETENCY DUE TO MENTAL

ILLNESS.

1. Hospitalization of any person under this Act, either voluntarily or involuntarily, shall not be deemed to constitute a finding of or to equate with nor raise a presumption of incompetency, or to cause the person so hospitalized to be deemed a lunatic, a person of unsound mind, or a person under legal disability for any purpose including but not limited to any circumstances to which sections four hundred forty-seven point seven (477.7), four hundred seventy-two point fifteen (472.15), five hundred forty-five point two (545.2), subsection thirteen (13), five hundred forty-five point eleven (545.11), subsection seven (7), five hundred forty-five point thirty-six (545.36), five hundred sixty-seven point seven (567.7), five hundred ninety-five point three (595.3), five hundred ninety-seven point six (597.6), five hundred ninety-eight point twenty-nine (598.29), six hundred fourteen point eight (614.8), six hundred fourteen point nineteen (614.19), six hundred fourteen point twenty-two (614.22), six hundred fourteen point twenty-four (614.24), six hundred fourteen point twenty-seven (614.27), six hundred twenty-two point six (622.6), six hundred thirty-three point two hundred forty-four (633.244), six hundred thirty-three point two hundred sixty-six (633.266), subsection four (4), and six hundred seventy-five point twenty-one (675.21) of the Code are applicable.

2. The applicant may, in initiating a petition for involuntary hospitalization of a person under section six (6) of this Act or at any subsequent time prior to conclusion of the involuntary hospitalization proceeding, also petition the court for a finding that the person is incompetent by reason of mental illness. The test of competence for the purpose of this section shall be whether the person possesses sufficient mind to understand in a reasonable manner the nature and effect of the act in which he or she is engaged; the fact that a person is mentally ill and in need of treatment

for that illness but because of the illness lacks sufficient judgment to make responsible decisions with respect to his or her hospitalization or treatment does not necessarily mean that that person is incapable of transacting business on any subject.

3. A hearing limited to the question of the person's competence and conducted in substantially the manner prescribed in sections six hundred thirty-three point five hundred fifty-two (633.552) through six hundred thirty-three point five hundred fifty-six (633.556) of the Code shall be held when:

a. The court is petitioned or proposes upon its own motion to find incompetent by reason of mental illness a person whose involuntary hospitalization has been ordered under sections thirteen (13) or fourteen (14) of this Act, and who contends that he or she is not incompetent; or

b. A person previously found incompetent by reason of mental illness under subsection two (2) of this section petitions the court for a finding that he or she is no longer incompetent and, after notice to the applicant who initiated the petition for hospitalization of the person and to any other party as directed by the court, an objection is filed with the court. The court may order a hearing on its own motion before acting on a petition filed under this paragraph. A petition by a person for a finding that he or she is no longer incompetent may be filed at any time without regard to whether the person is at that time hospitalized for treatment of mental illness.

4. Nothing in this Act shall preclude use of any other procedure authorized by law for declaring any person legally incompetent for reasons which may include mental illness, without regard to whether that person is or has been hospitalized for treatment of mental illness.

COMMENT: No substantive change has been made in either of the two preceding sections, as compared to the

previous versions of this draft bill. The terminology used in the second sentence of subsection 2, section 24, is based on Notes of Decisions, item 2, following section 229.40, Iowa Code Annotated.

It is recognized that a number of conforming amendments revising or repealing present statutes in accordance with this bill are necessary before the bill is ready for introduction. These amendments will be prepared as soon as possible.

APPENDIX I

Involuntary Hospitalization of the Mentally Ill--

I - Constitutional Issues

by Randall P. Bezanson

A threshold problem is where to start in a memorandum of this sort. Rather than proceeding on an analysis of the particular provisions of Iowa's current legislation or the proposed bill, I will address the issue more generally, defining some of the basic constitutional guarantees bearing on the commitment process. I will proceed, so far as possible, in a generally chronological manner.

At the outset, two points should be made. First, constitutional requirements should most appropriately play only a secondary role in any commitment legislation. The primary goal should be to seek the fairest, most accurate, and most effective process for the treatment and ultimate release of persons suffering from mental disorder. To the extent that such an "ideal" system based on these premises would satisfy constitutional requirements--or even exceed them--those constitutional requirements should play no important role. If for reasons of fairness and policy we provide more protection than the constitution requires, we should not retreat to the constitutional minimum simply because that document would require less. The issue is different, of course, where the constitution would require more, and it is from this perspective that I will address the question.

A second point is that a remarkable thorough analysis of the relevant state statutes and constitutional guarantees may be found in a 200-page article in a recent issue of the Harvard Law Review. Note, Developments in the Law--Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190 (1974).

The balance of this memorandum will be devoted to an enumerated list of selected constitutional issues that are raised by the current Iowa commitment statute and bear on the proposed statute.

1. The Statutory Standard for Commitment. The central constitutional issue raised under this heading concerns whether dangerousness in some form is a prerequisite for commitment to full-time hospitalization of the mentally ill. I think it can be safely stated that the clear and recent trend of decision is to require that a person exhibit dangerous tendencies as a precondition to full-time hospitalization. See, e.g., Cross v. Harris, 418 F. 2d 1095 (D.C. Cir, 1969); People v. Stoddard, 227 Cal. App. 2d 40 (Dist. Ct. App. 1964); Davy v. Sullivan, 354 F. Supp. 1320 (M.D. Ala. 1973); Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated and remanded on other grounds, 94 S. Ct. 713 (1974); Welsch v. Likins, No. 4-72-Civ. 451, slip op. at 15

(D. Minn., Feb. 15, 1974). The issue, of course, is more difficult than this. It appears from the cases that physical injury to self or others will suffice, as well as a threat of severe emotional injury to others. People v. Stoddard, supra.

Interestingly enough, there is a growing body of authority to the effect that the constitution requires commitment on the least restrictive terms, even in those cases where it is otherwise justified. See Lessard v. Schmidt, supra; Dixon v. Attorney General, 325 F. Supp. 966 (M.D. Pa. 1971); Kesselbrenner v. Anonymous, 33 N.Y. 2d 161 (1973); Welsch v. Likins, supra. This view is quite consistent with well-established constitutional doctrine in many other areas, and accordingly is deserving of substantial weight. Our proposed bill, as most recently amended, satisfies this constitutional requirement, for it permits commitment by the commission or district court for out-patient treatment. This is a position which I have held ever since completion of the commitment study in 1970, and I was very happy to see it incorporated in the recent draft.

Other issues, of course, abound in relation to the statutory standard for commitment: what is the permissible definition of mental illness; is the standard unconstitutionally vague; does the standard incorporate (as ours does) a requirement of "treatability"? Without going into these matters, my off-hand judgment is that the proposed bill satisfies the constitution in all pertinent respects. The old statute, both in its definition of mental illness and its failure to require that the committed patient be a fit subject for treatment in all cases, is deficient.

2. Procedural Rights--Notice. While the Supreme Court has not directly addressed the issue of the extent of due process protection which must be afforded the civilly committed person, its opinions in closely allied areas virtually preclude the view that due process does not apply. E.g., In re Gault, 387 U.S. 1 (1967); Goldberg v. Kelly, 397 U.S. 254 (1970); Richardson v. Perales, 402 U.S. 401 (1971); Jackson v. Indiana, 406 U.S. 715 (1972); Morrissey v. Brewer, 408 U.S. 471 (1972). With this in mind, I will simply offer my opinion as to those procedural protections which due process most likely requires. First, notice to the patient is most assuredly required; where notice would be ineffective or dangerous, emergency commitment and temporary detention under the safeguards prescribed in our bill would suffice. Whether or not notice is served on the prospective patient directly or through counsel if immediately retained may not be of great constitutional moment where custody is not immediate, but our bill provides for notice to both and is thus the best and safest means of providing clear notice.

3. Procedural Rights--Hearing. Detention prior to a hearing for purposes of evidence gathering and evaluation is not absolutely prohibited, but the permissible length of detention is circumscribed. The Lessard court held that a preliminary hearing must be held within 48 hours of custody. While a longer period may

well pass constitutional muster, there seems little reason to test the point, and the proposed bill doesn't, as a 48-hour period is prescribed there as well.

The preliminary hearing further serves to eliminate in large measure the time pressure for a full hearing. Our bill provides that the full hearing must take place within about 15 days of the preliminary hearing, and this is consistent with the opinion in the Lessard case. While a longer period may well pass constitutional scrutiny, any delay in excess of 20 or 25 days would, in my judgment, be pressing the outer limits. Indeed, as the normal period of hospitalization does not exceed 30 days in many cases, permitting a delay of that length would in effect eliminate the hearing altogether. The benchmark must be identified in view of the principle reasons or justifications for delay. Delay cannot at this stage be justified by a need for treatment, for commitment itself has not taken place, and therefore treatment of the patient before the hearing may raise substantial constitutional questions. Rather, the delay can be justified only in order that diagnosis be made and the state and individual have ample time to prepare for the hearing. In view of this a 15-day limitation would seem fully adequate in all but the rarest of cases.

4. Right to Counsel. While Iowa now provides appointed counsel for the prospective patient, mention should at least be made of the constitutional underpinnings of this right. In view of abundant Supreme Court authority in related areas, as well as most if not all recent cases decided in lower courts, there seems little room for argument that counsel need not be provided. And it seems clear as well that the right to counsel attaches immediately after the information has been filed or the patient has been taken into custody. E.g., In re Gault, supra; Heryford v. Parker, 396 F. 2d 393 (10th Cir. 1968); Lessard v. Schmidt, supra.

5. Right to Jury Trial. The right to a jury trial in the civil commitment setting has not attracted much attention in prior decisions, although a few recent cases have held that juries are constitutionally mandated. See Lessard v. Schmidt; Quesnell v. State, 517 P. 2d 568 (Wash. 1973). The weight of authority, however, seems contrary to this position, as the Supreme Court has refused to extend the jury trial right in highly analogous contexts. In re Gault, supra; McKeiver v. Pennsylvania, 403 U.S. 528 (1971). The weight of reason, as well, disfavors the jury trial, at least when not requested by the patient, for the likelihood of prejudice on the jury's part in this context seems accute.

6. Right to Judicial Officer. The reasons supportive of a right to jury trial, however, are that through the device of the jury the nonmedical components of the commitment decision are separated from the medical judgment. Commitment is not strictly a medical decision. Accordingly, while a jury may not be required, there is some force in the argument that a judge or panel composed of nonmedical personnel (subject to immediate and direct review by

a court) must make the ultimate commitment decision. This view is all the more forceful in light of the difficult legal questions which will constantly arise in the commitment setting: procedural rights; standard of proof, and the like. See Lessard v. Schmidt. It is noteworthy, as well, that many states now require judges in the commitment process, and at least five states either require or permit jury trial. Alaska Stat. section 47.30.070(h); Tex. Rev. Civ. Stat. ann. arts 5547-48; Ala. Code tit. 45, section 210; Ark. Stat. Ann. 6 59-101; D.C. Code ann. section 21-545(a). (Alabama and Arkansas make the right discretionary with the judge.)

7. Standard of Proof. It seems well settled that at the very least the prospective patient must be shown to be seriously mentally ill by clear and convincing evidence or by a preponderance of the evidence. The real question lies elsewhere. A number of fairly recent decisions have taken the position that serious mental illness must be established beyond a reasonable doubt. See, e.g., Lessard v. Schmidt, supra; In re Bailey, 482 F. 2d 648 (D.C. Cir. 1973). The reasonable doubt standard has been required in the analogous juvenile setting, In re Winship, 397 U.S. 358 (1970), although the nature of the issues to be determined in the civil commitment setting are arguable more vague than in the juvenile setting, and thus one might conclude that the reasonable doubt standard would simply be unworkable in the instant context. While I believe that there is much truth to this observation, it must be carefully employed. Any admission that mental illness cannot be proved beyond a reasonable doubt raises serious questions about the legitimacy of civil commitment itself. I would hate to tell someone that the standard of proof is less simply because we know we are guessing or speculating about the very condition with which we are so concerned. For present purposes, however, I think a requirement of proof by clear and convincing evidence, coupled with the extensive diagnosis and the periodic review which is required under the proposed bill, is constitutionally sufficient.

8. Miscellaneous Matters. By labelling the following issues as "miscellaneous" I do not intend to depreciate their significance, but rather to indicate that my analysis of them has not been as thorough. First, I think the patient's presence at the hearing is constitutionally required, at least in the absence of substantial disruption or a clear and unequivocal waiver of that right by the individual. A right to appeal is also required, with appointed counsel at this stage, as now provided in the Iowa Code. So also, I think, is a periodic reporting of the patient's status required, although the relevant time intervals are not clear. Finally, a right to treatment has become almost universally recognized, although many of the cases justify it on statutory rather than constitutional grounds. Nonetheless, treatment is the only justification for commitment and involuntary hospitalization, and it would shock one's conscience to say that no right to treatment existed in light of this. An exhaustive list of cases decided on this point can be found in the Harvard Law Review article cited above, at pages 1316-1344.

There are two other issues on which I have done no research, but about which I have some tentative feelings. First, does the prospective patient have a privilege against self-incrimination? If so, the medical examination required under the proposed bill would be substantially undermined. Second, may parents constitutionally "commit" their children against their will on a voluntary basis? While this issue is not clear from a constitutional point of view, I think a case can easily be imagined where a child hospitalized under such conditions could successfully challenge the validity of his or her confinement.

In my judgment the proposed bill satisfies the constitution. The current statutes, however, fail to do so in significant respects.

APPENDIX II

COUNTY OFFICERS COORDINATING COMMITTEE

December 6, 1974

Senator John S. Murray
Chairman, Sub-Committee on Commitment Laws
Mental Health and Juvenile Study Committee
c/o Iowa Legislative Service Bureau
State House
Des Moines, Iowa 50319

Dear Senator Murray:

The County Officers Coordinating Committee at their regular meeting on November 20, 1974, discussed at length the proposed revision of Iowa Law pertaining to civil commitment for the treatment of mental illness.

The Committee, organized in 1955, is comprised of representatives from the County Supervisors Association, County Auditors Association, County Clerks Association, County Home Administrators, and Administrators of the six institutions within the Division of Mental Health Resources, and Central Office personnel.

The new commitment bill authorizes judges to delegate commitment to a Judicial Hospitalization Commission. This, in fact, is practically identical to the present Hospitalization Commission process, except that it would substitute a lay person for the Clerk. If the present law is unconstitutional, this part of the new commitment bill would also be unconstitutional. It would also place an additional burden on the already overloaded courts, greatly increase the duties of the Clerks, and there is an indication the administrative cost to the counties would be considerable.

For the above-stated reasons, the Committee went on record as opposing the enactment of this bill.

Sincerely,

COUNTY OFFICERS COORDINATING COMMITTEE

Wilbur Rust, President
Grundy County Auditor

WR/aw

S.F. _____ H.F. _____

APPENDIX III

Judicial Hospitalization Commission

The following is the proposed judicial hospitalization commission section which appeared in the third version of Mental Health and Juvenile Institutions Study Committee Draft Bill No. 6, but was deleted from the fourth version for the reasons explained in this supplementary report of the Commitment Laws Subcommittee.

Sec. ___. NEW SECTION. JUDICIAL HOSPITALIZATION COMMISSION.

1. As soon as practicable after the adoption of this Act the judges in each judicial district shall meet and shall determine, individually for each county in the district, whether it is practical for the district court in that county to perform the duties prescribed by sections seven (7) through sixteen (16), inclusive, of this Act. In any county in which the judges find it impractical for the district court of that county to so act, the chief judge of the district shall appoint a judicial hospitalization commission. The judges in any district may at any time review their determination, previously made under this subsection with respect to any county in the district, and pursuant to that review may establish a judicial hospitalization commission, or abolish it, in that county.

2. Each judicial hospitalization commission shall consist of three members, all of whom shall be residents of the county in which the commission is established. One member, who shall preside in all proceedings of the commission, shall be an attorney engaged in the practice of law in that county, one member shall be a physician engaged in the practice of medicine in that county, and the third member shall be a person who has demonstrated an informed interest in the field

of mental health. For purposes of this subsection, such interest may be demonstrated by volunteer work in areas related to mental health as well as by professional experience in related fields.

3. When established in any county, the judicial hospitalization commission shall perform all of the duties which would otherwise be performed by the district court of that county pursuant to sections seven (7) through sixteen (16) of this Act, inclusive, except that if a request is made for an order that a respondent be immediately taken into custody under section eleven (11) of this Act, the request must be referred to and such order may be entered only by a judge of the district court.

4. Any respondent with respect to whom the judicial hospitalization commission has found the contention that he or she is seriously mentally ill sustained by clear and convincing evidence presented at a hearing held under section twelve (12) of this Act, or the respondent's next friend, may appeal from that finding to the district court by giving the clerk thereof, within thirty days after the commission's finding has been made, notice in writing that an appeal is taken. The notice may be signed by the appellant or his agent, next friend, guardian or attorney. When so appealed, the matter shall stand for trial de novo. Upon appeal, the court shall schedule a hospitalization hearing at the earliest practicable time. The court may, but shall not be required to, order a new examination of the appellant by one or more licensed physicians.

5. If the appellant is in custody under the jurisdiction of the judicial hospitalization commission at the time of service of the notice of appeal, he shall be discharged from custody unless a judge of the district court enters, or has previously entered, an order that the appellant be taken into immediate custody under section eleven (11) of this Act, in which case the appellant shall be detained

as provided in that section until the hospitalization hearing before the district court. If the appellant is in the custody of a hospital at the time of service of the notice of appeal, he shall be discharged from custody pending disposition of the appeal unless the chief medical officer, not later than the end of the next secular day on which the office of the clerk is open and which follows service of the notice of appeal, files with the clerk a certification that in the chief medical officer's opinion the appellant is seriously mentally ill. In that case, the appellant shall remain in custody of the hospital until the hospitalization hearing before the district court.

6. The hospitalization hearing before the district court shall be held, and the judge's finding shall be made and an appropriate order entered, as prescribed by sections twelve (12) and thirteen (13) of this Act. If the judge orders the appellant hospitalized for a complete psychiatric evaluation, jurisdiction of the matter shall revert to the judicial hospitalization commission.

7. Each member of the judicial hospitalization commission shall receive forty dollars per diem for each day or portion of a day actually devoted to the duties of the office, and shall be reimbursed for actual and necessary expenses incurred in the course of such service.

8. The clerk of the district court in each county in which a judicial hospitalization commission is established shall provide the clerical services required by the commission in the performance of its official duties.

COMMENT: This section seeks to effect a compromise between the view that only a court may constitutionally involuntarily hospitalize (i.e., deprive of liberty) a person, and the urgent representations to the legislative Subcommittee that in many areas of the state it is simply impossible

for the courts, as presently organized, to assume this additional burden. The proposed "Judicial Hospitalization Commission" would be similar in many respects to the present Commission of Hospitalization, but would be legally an arm of the court. Also, the clerk of court would no longer be a member, but would continue to provide staff services to the Commission.

The Commission would exercise nearly all of the functions of the district court, if the judges of the district conclude that it is not feasible for the district court itself to perform this role in any given county. The sole exception is that only a district judge could issue an order to take into immediate custody a person whose involuntary hospitalization is being sought. The finding of the Commission could be appealed by any person ordered hospitalized for a psychiatric evaluation, but if the finding should be upheld upon trial in the district court, jurisdiction reverts to the Commission to receive the required reports from the hospital, etc.