Clear but Unconvincing: Revisiting *Addington v. Texas*

Rachel Anne Rein

Abstract: This article revisits the United States Supreme Court case, Addington v. Texas, in which the Court held that the Fourteenth Amendment requires a "clear and convincing" standard for indefinite involuntary civil commitment to a state mental hospital. The Court should have applied a reasonable-doubt standard to involuntary civil commitments, not a "clear and convincing" standard, violating patients' liberty interests. Moreover, a "clear and convincing" standard misuses states' parent and police powers, as it hurts patients' health and subverts public safety. Last, the Court should leave the problem of the unreliability of professional psychiatric opinions to experts and the legislature. Given that COVID-19 swept the nation, disproportionately harming psychiatric patients, it is critical to revisit Addington v. Texas to protect some of the most vulnerable people.

Keywords: Due process; Standards of review; Mental health; Psychiatry; Civil.

1. Introduction

1.1. Background to Addington v. Texas

Involuntarily committed patients face a somber fate: deprivation of their liberty[1]. Unlike patients who enter psychiatric hospitals on a voluntary basis[2], involuntarily committed patients lose the right to choose whether they will be hospitalized[3]. They have equally little choice as to when they leave[4]. Unsurprisingly, forcibly committed

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1. See *Addington v. Texas*, 441 U.S. 418, 425–26 (1979).

2. See Dan A. Lewis et al., *The Negotiation of Involuntary Civil Commitment*, 18 Law & Soc'y Rev. 629, 630 (1984).

3. See John A. Menninger, *Involuntary Treatment: Hospitalization and Medications*, Brown U., available at https://www.brown.edu/Courses/BI_278/Other/Clerkship/Didactics/Readings/INVOLUNTARY%20TREATMENT.pdf (last visited November 17, 2021).

4. See *id.*

patients have clamored for courts to either justify their detention or free them[5].

So, in the late twentieth century, courts across the nation wrestled with the question, under what circumstances can a court civilly commit a person against his will[6]? For example, in the 1975 Supreme Court case *O'Connor v. Donaldson*, the Court held that a person must have a mental disability as a result of which the person is dangerous to himself or others, with no less restrictive alternative available, before a court can involuntarily civilly commit him[7].

Around the same time, courts asked *when* they could civilly commit a person, they also began to ask what they needed to do so[8]. In other words, what burden of proof must the State meet to prove a person mentally ill or dangerous to himself or others?

Three burdens of proof developed from decades of common law apply to the discussion: a "preponderance of the evidence," "clear and convincing" evidence, and evidence "beyond a reasonable doubt"[9]. First, a "preponderance of the evidence" standard requires a party to present evidence that more likely than not proves the issue at hand[10]. Next, a "clear and convincing" burden requires greater proof; it requires the evidence to be highly and substantially more probable to be true than not[11]. Even more exacting, a reasonable-doubt standard forces evidence to inspire near-certainty[12]. Though some courts have hesitated to apply the reasonable-doubt standard to civil cases, other

5. See, for example, *Vitek v. Jones*, 445 U.S. 480 (1980); *O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972); *Matter of Anonymous ("Billie Boggs") v. NYC HHC*, 522 NYS 2d 407 (NY Co. 1987).

6. See *id.*

7. See *O'Connor*, 422 U.S. at 563 (cited in note 5).

8. See, for example, *Lessard*, 349 F. Supp. at 1078 (cited in note 5); *Superintendent of Worcester State Hosp. v. Hagberg*, 372 N.E.2d 242 (Mass. 1978) (requiring proof beyond a reasonable-doubt in a civil commitment case); *Andrews, petitioner*, 334 N.E.2d 15 (Mass. 1975) (requiring proof beyond a reasonable- doubt for committing sexually dangerous persons).

9. See generally Charlene Sabini, *Burden of Proof: An Essay of Definition*, Nals.org (April 19, 2018), available at https://www.nals.org/blogpost/1359892/300369/Burden-of-Proof-An-Essay-of-Definition (last visited November 17, 2021).

10. See *Preponderance of the Evidence*, Black's Law Dictionary, ed. X, 2014.

11. See *Clear and Convincing Evidence*, Black's Law Dictionary, ed. X, 2014.

12. See *Reasonable Doubt*, Black's Law Dictionary, ed. X, 2014.

courts have done so[13]. For example, in Massachusetts, matters require proof beyond a reasonable doubt when a person "receives a stigma at least as great as that flowing from a criminal conviction" and "faces a potential loss of liberty"[14]. And some courts have applied the reasonable-doubt standard to civil commitments, noting either the stigma of mental illness or the loss of liberty from commitment[15].

1.2. Addington v. Texas

The following patient's case warrants similar considerations of stigma and freedom. Frank Addington was no stranger to civil commitment. Suffering from delusions, he had been civilly committed seven times between 1969 and 1975 for mental and emotional disorders[16]. He had threatened his parents and damaged property at his and his parents' homes in Texas[17]. When hospitalized, he had been involved in assaultive episodes[18].

On December 18, 1975, Mr. Addington was arrested for a threat against his mother, who petitioned for his indefinite commitment to a state institution[19]. Afterward, a county psychiatric examiner interviewed Mr. Addington and opined that he was mentally ill and needed hospitalization in a mental hospital[20].

Like other courts considering whether to involuntarily commit a patient, the Texas trial court asked the jury to decide the case based on two questions involving evidentiary standards. First, the court asked whether Mr. Addington was mentally ill based on "clear, unequivocal [,] and convincing evidence"[21]. Then, the court inquired whether, under the same standard, Mr. Addington required hospitalization for

13. See, for example, *Doe v. Doe*, 385 N.E.2d 995 (Mass. 1979); *Fazio v. Fazio*, 378 N.E.2d 951 (Mass. 1978); *Hagberg*, 372 N.E.2d at 242 (cited in note 8).

14. See *In re Guardianship of Roe,* 383 Mass. 415, 423, 421 N.E.2d 40 (1980).

15. See *Lessard*, 349 F. Supp. 1078 (cited in note 5); *Hagberg,* 372 N.E.2d at 245 (cited in note 8); *Andrews, petitioner,* 334 N.E.2d at 15 (cited in note 8).

16. See *Addington*, 441 U.S. at 420 (cited in note 1).

17. See *ibidem*.

18. See *Addington*, 441 U.S. at 421 (cited in note 1).

19. See *id* at 420.

20. See *ibidem.*

21. See *Addington*, 441 U.S. at 421 (cited in note 1).

his own welfare and protection or to protect others[22]. The jury found Mr. Addington mentally ill and found that he required hospitalization[23]. Mr. Addington objected on multiple grounds, including the court's refusal to use a reasonable-doubt standard of proof instead of the "clear, unequivocal, and convincing" standard it employed[24].

Upon appeal, the Texas Court of Civil Appeals reversed, agreeing with Mr. Addington that his commitment required a reasonable-doubt standard[25]. But then, the Texas Supreme Court reinstated the trial court's decision[26]. The Texas Supreme Court relied primarily on *State v. Turner*[27] where the Texas Supreme Court had previously held that the "preponderance" standard satisfied due process in civil commitment cases[28].

Mr. Addington appealed that decision to the United States Supreme Court, with some success. In *Addington v. Texas*, the Supreme Court adopted a more stringent standard than the Texas Supreme Court, holding that the Fourteenth Amendment requires a "clear and convincing" standard for indefinite involuntary civil commitment to a state mental hospital[29]. The Court found the Texas Supreme Court's "preponderance of the evidence" standard too lenient to meet due process guarantees[30], considering the loss of liberty the patient Mr. Addington faced. However, the Court declined to raise the constitutional minimum to "beyond a reasonable doubt," as Mr. Addington had urged[31].

The Court's decision reflected its wariness of applying a reasonable-doubt standard "too broadly or casually" in noncriminal cases[32]. Initially, the Court emphasized that it had repeatedly recognized the

22. See *ibidem.*
23. See *ibidem.*
24. See *ibidem.*
25. See *Addington*, 441 U.S. at 422 (cited in note 1).
26. See *id.* at 418.
27. See *ibidem.*
28. See *State v. Turner*, 556 S.W.2d 563 (Tex. 1977).
29. See *Addington*, 441 U.S. at 418 (cited in note 1).
30. See *id.* at 432.
31. See *id.* at 419.
32. See *id.* at 428.

severe loss of liberty that committed patients suffer[33]. Moreover, the Court admitted that patients' adverse social consequences from civil commitment were "indisputable"[34]. The Court cautioned that these consequences could have a "very significant impact" on a person[35]. However, the Court also sought to avoid treading upon the unique place the criminal justice system holds in the legal system[36]. Furthermore, the Court reasoned that because psychiatric diagnosis is often uncertain, the State may never be able to meet a reasonable-doubt standard[37]. Accordingly, the Court justified a standard in the middle: "clear and convincing" evidence[38].

1.3. Why Does Addington Matter?

This article addresses whether the Supreme Court rightly decided *Addington*, in which it held that the Fourteenth Amendment requires a "clear and convincing" standard for indefinite involuntary civil commitment to a state mental hospital.

The Supreme Court failed to go far enough in *Addington* when it adopted a "clear and convincing" burden of proof for involuntary civil commitment. Instead of a "clear and convincing" standard, the Court should have applied a reasonable-doubt standard to involuntary civil commitments.

First, in adopting a "clear and convincing" standard, the Court treads upon involuntarily committed patients' liberty interests. Next, a "clear and convincing" standard fails to protect states' parent and police powers, as the standard hurts patients' health and subverts public safety. Finally, the Court should leave the problem of the unreliability of professional psychiatric opinions to experts and the legislature.

33. See *Addington*, 441 U.S. at 425 (cited in note 1) (citing *Jackson v. Indiana*, 406 U.S. 715 (1972); *Humphrey v. Cady,* 405 U.S. 504 (1972); *In re Gault,* 387 U.S. 1 (1967); *Specht v. Patterson*, 386 U.S. 605 (1967).

34. See *Addington*, 441 U.S. at 425 (cited in note 1).

35. See *id.* at 426.

36. See *id.* at 423.

37. See *id.* at 432.

38. See *Addington*, 441 U.S. at 433 (cited in note 1).

This issue is timely because the COVID-19 exacerbated psychiatric health issues across the nation[39], and subpar institutional living conditions further abrogated the rights of involuntarily institutionalized patients[40]. Patients confined to close quarters found themselves at heightened risk of coronavirus[41]. As the pandemic continues, it is critical we revisit *Addington* to ensure patients receive their due rights under the law.

2. Analysis

2.1. The Court Treads Upon Involuntarily Committed Patients' Liberty Interests

Courts must weigh states parent and police powers against individuals' liberty interests[42], but the Supreme Court's balancing exercise in *Addington* falls short of fairly protecting patients' freedoms. Under the Fourteenth Amendment's Due Process Clause, the Court has recognized a person's right to privacy[43]. Also, lower courts have defined the constitutional right to privacy as "an expression of the sanctity of

39. See Allison Abbott, *COVID's Mental-health Toll: How Scientists are Tracking a Surge in Depression*, Nature.com (February 3, 2021), available at https://www.nature.com/articles/d41586-021-00175-z (showing an increase in reported symptoms of anxiety or depression from 11% in 2019 to 42% in December 2020) (last visited November, 17 2021).

40. See Ermal Bojdani et al., *COVID-19 Pandemic: Impact on Psychiatric Care in the United States*, Psychiatry Research, May 2020, at 3–4 (listing lack of beds, of face to face interaction, of in-person programming, of communal dining, and of visitors' policies as harmful to psychiatric patients' health during the COVID-19 pandemic); see also Muhammad Rahman et al., *Mental Distress and Human Rights Violations During COVID-19: A Rapid Review of the Evidence Informing Rights, Mental Health Needs, and Public Policy Around Vulnerable Populations,* 11 Front Psychiatry, January 2021, at 1 and at 11.

41. See also Bojdani et al., *COVID-19 Pandemic* at 2 (cited in note 40) (indicating that it can be difficult to get psychotic patients to wear masks, that some patients have difficulty maintaining personal hygiene, and that psychiatric staff are not trained in infectious disease protocols, increasing the risk of coronavirus to staff and patients).

42. See *Youngberg v. Romeo*, 457 U.S. 307, 327 (1982).

43. See *Roe v. Wade*, 410 U.S. 113 (1973). See also *Stanley v. Georgia*, 394 U.S. 557 (1969); *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965).

individual free choice and self-determination as fundamental constituents of life"[44].

The *Addington* Court posited that civilly committed patients lose less liberty than prisoners[45]. Consequently, patients do not need a reasonable-doubt standard to protect them. However, this differentiation does not hold up to scrutiny. Institutionalization robs patients of their privacy[46] much like incarceration does[47], possibly even more so[48]. Institutionalization denies patients their individuality, restricts their movement, and forbids them from exercising their autonomy[49]: involuntarily committed patients live under lock and key like prisoners[50]. They are told when to eat and where to sleep by "techs"[51], people who assume a role akin to a jail's guards. Institutionalized patients are stripped of their clothing[52] and sometimes given uniforms to wear, like

44. See *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 426 (Mass. 1977).

45. See *Addington*, 441 U.S. at 423, 428 (cited in note 1).

46. See Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 Cal. l. Rev. 54, 55 (1982) ("The balance between individual liberty and autonomy on the one hand, and the state's paternalistic right to confine and treat persons involuntarily on the other, has clearly shifted to a preference for liberty").

47. See Zachary Groendyk, Note, *"It Takes a Lot to Get Into Bellevue": A Pro-Rights Critique of New York's Involuntary Commitment Law*, 40 Fordham Urb. L.J. 549 (2012). See also Ketema Ross, *I Spent Seven Years Locked in a Human Warehouse*, Politico (April 16, 2015), available at https://www.politico.com/magazine/story/2015/04/mental-institution-mental-health-policy-117061 (noting that patients were forbidden from visiting each other's rooms, from sharing food, from taking walks on hospital grounds, from leaving, even from working out using a pillow stuffed with books as a weight) (last visited November 17, 2021).

48. See Ross, *I Spent Seven Years Locked in a Human Warehouse* (cited in note 47) ("Many people with mental illness would love to have the rights that are given to convicted criminals").

49. See *id.*

50. See Margaret Parish, *Preventing Suicide in Locked vs. Unlocked Psychiatric Units*, Austen Riggs (August 3, 2016), available at https://www.austenriggs.org/blog-post/preventing-suicide-locked-vs-unlocked-psychiatricunits (last visited November 17, 2021).

51. See Letter from Anonymous, *When We Don't Value Psychiatric Care*, Atlantic (December 20, 2016), available at https://www.theatlantic.com/notes/2017/01/ect/512102/ (last visited November 17, 2021).

52. See Dinah Miller & Annette Hanson, *Violent Behavior and Involuntary Commitment: Ethical and Clinical Considerations*, Psychiatric Times (February 28, 2020),

how prisoners are given jumpsuits. Similar to how one former prisoner said that prison guards treat incarcerated people as "subhuman"[53], one former psychiatric patient said that the "cold, sterile" environment of a mental ward guts one's identity and humanity[54].

Indeed, as with prisoners, patients' deprivation of freedom extends beyond their release from the hospital and even a "short detention" in a mental hospital can affect a person's ability to function in the outside world[55]. For example, learned passivity and the stigma attached to mental illnesses may prevent former patients from gaining employment, forming relationships, and pursuing other goals[56]. For the reasons just exposed, without proper resources upon release from mental hospitals, former patients may fail to reach their full potential[57].

According to the Court in its earlier case In re Winship, requiring the government to meet a reasonable-doubt burden "establish[es] the moral force of the law" when the law "deprive[s] an individual of his liberty" [58]. Thus, considering that commitment crushes patients' free choice and self-determination – the foundation of liberty and privacy

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available at https://www.psychiatrictimes.com/view/violent-behavior-and-involuntary-commitment-ethical-and-clinical-considerations (last visited November 17, 2021).

53. See Nicole Lewis, *How We Survived COVID-19 in Prison*, The Marshall Project (April 22, 2021), available at https://www.themarshallproject.org/2021/04/23/how-we-survived-covid-19-in-prison (last visited November 17, 2021).

54. See Ross, *I Spent Seven Years Locked in a Human Warehouse* (cited in note 47).

55. See *Lessard*, 349 F. Supp. 1078, 1091 (cited in note 5); see also *Youngberg v. Romeo*, 457 U.S. 307, 327 (1982) (Blackmun, J. et al., concurring) (It is argued that due process guaranteed patients training necessary to prevent them from losing the skills, like basic self-care, that they entered commitment with).

56. See Brian K. Ahmedani, *Mental Health Stigma: Society, Individuals, and the Profession*, 8 J. Soc. Work Values & Ethics 1, 5 (2011) (noting that the stigma of mental illness may impact mentally ill people's employment and relationships, and noting how a mental illness label may lead to status loss and discrimination); see also H. Richard Lamb & Leona L. Bachrach, *Some Perspectives on Deinstitutionalization*, Psychiatric Online (August 1, 2001), available at https://ps.psychiatryonline.org/doi/10.1176/appi.ps.52.8.1039 (indicating that adequate community resources must be provided for patients with learned passivity from long hospitalizations, so patients can realize their social and vocational potential) (last visited November 17, 2021).

57. See Lamb & Bachrach, *Some Perspectives on Deinstitutionalization* (cited in note 56).

58. See *In re Winship*, 397 U.S. 358, 364 (1970).

– similarly to criminal law, the Court in Addington should have employed a reasonable-doubt burden.

2.2. A "Clear and Convincing" Standard Fails to Protect States' Parent and Police Powers

A "clear and convincing" standard fails to secure personal freedoms. It also fails to protect individual and public health and safety. In civil commitment, states' parent power protects mentally ill people from themselves, and states' police power protects the public from dangerous patients[59]. *Addington,* therefore, avoided providing federally for patients, leaving the matter under powers traditionally within autonomous states' purview[60]. In other words, the Court leaves the states free to enact stronger burden of proof[61].

The Court's lenient "clear and convincing" standard impinges upon states' interests by inviting undue commitment[62], which threatens patients and the public. When patients first arrive, long waits in emergency rooms escalate patients' aggression and irritation[63]. Then, during patients' stays, doctors may medicate them with medications that carry severe risks, including robbing patients of their independence. In fact, medications deemed "chemical straightjackets" for their unique ability to subdue patients for prolonged periods of time, are no longer used sparingly by doctors for their original purpose to treat

59. See *Addington*, 441 U.S. at 426 (cited in note 1).

60. See *id.* at 430.

61. See *ibidem.*

62. See, for example, Lonnie R. Snowden et al., *Overrepresentation of Black Americans in Psychiatric Inpatient Care*, 60 Psychiatric Servs. 779 (2009) (showing that Black Americans have a higher chance of being civilly committed during their lifetime than white Americans, even when controlling for any lifetime mental disorder, lifetime receipt of psychotherapy or counseling, income, employment, marital status, age, education, and gender); Christie Thompson, *When Going to the Hospital Is Just as Bad as Jail*, Marshall Project (November 8, 2020), available at https://www.themarshallproject.org/2020/11/08/when-going-to-the-hospital-is-just-as-bad-as-jail (noting high involuntary detention rates for Black Americans, partly because first responders are too quick to hospitalize) (last visited November 17, 2021).

63. See Miller & Hanson, *Violent Behavior and Involuntary Commitment* (cited in note 52).

acute psychosis[64]. Instead, they are now used to quite aggressive or disruptive patients, even when these patients are completely lucid[65]. Beyond their intended uses (whether justifiable or not), medications that doctors prescribe to psychiatric patients can also cause undesired side effects that take away basic skills, like patients' ability to drive[66]. It results clear how restrictive civil commitment is on one's liberty.

But this is not all. Patients' autonomy may be further violated through physical and sexual assaults, occurring in mental health hospitals and other facilities[67]. Patients are often neither safe with staff nor with their peers, as both staff and other patients perpetrate these assaults[68]. One source even estimates that almost one in ten patients inside a mental health facility will experience sexual coercion, misconduct, or assault there[69]. It also happens that some patients lose the greatest liberty of all: their lives. For example, just two years ago, at Aurora Las Encinas Mental Health Hospital in Pasadena, California, a patient stopped breathing after five staff members restrained him on the ground[70] and the patient died. State investigators later found that the staff had not been trained how to properly restrain a patient[71]. Upon release, hospitals funnel traumatized patients[72], now suffering

64. See Joanna Moncrieff, *Story of Antipsychotics is One of Myth and Misrepresentation,* The Conversation (September 20, 2013), available at https://theconversation.com/story-of-antipsychotics-is-one-of-myth-and-misrepresentation-18306 (last visited November 17, 2021).

65. See *id.*

66. See Chuck Weller, *Forced Administration of Antipsychotic Drugs to Civilly Committed Mental Patients in Nevada: A Remedy Without a Clear Statutory Authorization,* 11 Nev. L. J. 759, 759–60 (2011) (noting that antipsychotics prescribed to patients have side effects and can cause tardive dyskinesia, a condition that takes away basic skills, like the ability to drive).

67. See B. Christopher Frueh et al., *Patients' Reports of Traumatic or Harmful Experiences Within the Psychiatric Setting,* 56 Psychiatrice Servs. 1123 (2005).

68. See Brian Barnett, Addressing Sexual Violence in Psychiatric Facilities, 71 Psychiatric Servs., 959, 959 (2020).

69. See *id.*

70. See Soumya Karlamangla, *Their Kids Died on the Psych Ward. They Were Far from Alone, a Times Investigation Found,* LA Times (December 1, 2019), available at https://www.latimes.com/california/story/2019-12-01/psychiatric-hospital-deaths-california (last visited November 17, 2021).

71. See *id.*

72. See Thompson, *When Going to the Hospital Is Just as Bad as Jail* (cited in note 62) ("Many who have endured a short-term hospital stay say the experience of being

from more severe symptoms[73], back into the public[74]. Many of these patients, without long-term care, subsequently commit crimes, though crime data specifically referring to patients released from mental health hospitals is lacking[75]. Instead of protecting the public, the State creates a revolving door of treatment that puts the public at risk[76].

Some scholars fear that the more restrictive the standard for hospitalization, the more psychiatric patients will become a burden for jails or the streets[77]. However, state courts may still choose whether to employ a dangerousness standard (a patient must be a danger to himself or others) or a welfare standard (commitment must be necessary for the patient's wellbeing)[78]. Moreover, in the unlikely case that hospitals

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held against their will in a psychiatric ward was as traumatizing as being arrested").

73. See *Lessard*, 349 F. Supp. at 1087, n.18 (cited in note 5) ("[There is] substantial evidence that any lengthy hospitalization, particularly where it is involuntary, may greatly increase the symptoms of mental illness and make adjustment to society more difficult [...] The effects may not be limited to those resulting from prejudice [...] Although 7 days may not appear to some to be a very long time, experience has indicated that any kind of forcible detention of a person in an alien environment may seriously affect him in the first few days of detention, leading to all sorts of acute traumatic and iatrogenic symptoms and troubles [...] things that are caused by the very act of hospitalization which is supposed to be therapeutic; in other words, the hospitalization process itself causes the disturbance rather than the disturbance requiring hospitalization").

74. See Miller & Hanson, *Violent Behavior and Involuntary Commitment* (cited in note 52).

75. See Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness*, 66 Case W. Rsrv. L. Rev. 657, 660–61 (2016).

76. See Daniel Yohanna, *Deinstitutionalization of People with Mental Illness: Causes and Consequences*, 15 Am. Med. Ass'n J. Ethics 886, 889 (2013) ("Patients [with mental illnesses] who are violent, have criminal histories [...] have history of damage to property [...] cannot be easily placed. They are often discharged back to the streets where they started").

77. See Lamb & Bachrach, *Some Perspectives on Deinstitutionalization* (cited in note 56) ("The two American Psychiatric Association task forces on the homeless mentally ill concluded that this problem is the result not of deinstitutionalization per se, but of the way it has been implemented. [...] There has been much concern since the 1970s about the numbers of mentally ill persons in our jails and prisons").

78. See R. Levinson et al., *The Impact of a Change in Commitment Procedures on the Character of Involuntary Psychiatric Patients*, 29 J. Forensic Sci. 566, 566 (1984) ("The statutory requirements for involuntary civil psychiatric confinement have become

under-commit patients[79], states would still have the choice to aggressively invest in community mental health resources and pursue less restrictive alternatives for patients, such as community care[80].

Because civil commitment is risky to the public, and even potentially fatal to patients, the Court should ensure that the only patients that courts involuntarily commit are those who the State can prove belong there beyond a shadow of a doubt.

2.3. The Court Falters from the Uncertainty of Professional Psychiatric Opinions

Finally, the Court gives short shrift to the subjectivity of professional opinions in involuntary civil commitment proceedings. In *Addington*, the Court said that because professional mental health opinions are fallible, the State may always fail to meet a reasonable doubt standard[81]. So, the Court reasoned, a standard that the State can meet with current psychiatric expert opinions, a "clear and convincing" standard, is more appropriate for involuntary psychiatric hospitalization. The subjectivity of psychiatric diagnosis is indeed problematic[82]. However, the Court should leave this puzzle for doctors and researchers, instead of letting it dictate a more lenient burden of proof.

Psychiatrists and psychologists often disagree about patients' conditions[83]. For example, in the famous "Billie Boggs" case, doctors

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increasingly restrictive. [...] A newly elected judge instituted changes requiring affiants to claim the subject was "dangerous" to self or others"); see N.Y. State Office of Mental Health, *Mental Hygiene Law – Admissions Process*, available at https://omh.ny.gov/omhweb/forensic/manual/html/mhl_admissions.htm (last visited November 17, 2021) (providing an example of New York State's mental hygiene commitment laws).

79. See J. Ray Hays, *The Role of Addington v. Texas on Involuntary Civil Commitment*, 65 Psych Reps. 1211, 1213 (1989).

80. See Olmstead v. L. C., 527 U.S. 581 (1999) (holding that the State is responsible for providing community-based treatment to qualified persons with disabilities and requiring states to stop segregating people with disabilities unnecessarily).

81. See *Addington*, 441 U.S. at 429 (cited in note 1).

82. See Shivani Nishar, *The Legacy Of "Deinstitutionalization"*, Mental Health Am. (July 29, 2020), available at https://www.mhanational.org/blog/legacy-deinstitutionalization (last visited November 17, 2021).

83. See Stijn Vanheule et al., *Reliability in Psychiatric Diagnosis with the DSM: Old Wine in New Barrels*, 83 Psychoter. & Psychosom 313, 313–14 (2014) (indicating

interpreted Joyce Brown's actions and words, including running into traffic and yelling epithets, in vastly different ways from irrational, psychotic, and suicidal to rational and self-protective[84]. Some doctors believed Ms. Brown was trying to end her own life and acted violently due to mental imbalance. At least one doctor, however, believed Ms. Brown's actions were a conscious, pained reaction to passerby treating her as less than human. More recently, in the Jodi Arias criminal murder trial, mental health experts disagreed on whether Ms. Arias suffered from Posttraumatic Stress Disorder or Borderline Personality Disorder[85]. While some theorized that Ms. Arias's obsessive and erratic behavior stemmed from trauma from her partner Travis's alleged abuse, others thought that Ms. Arias's actions and feelings were in line with long-standing personality characteristics. Even more worrisome, doctors consistently overpredict prospective patients' dangerousness to others[86]. Furthermore, marginalized groups suffer the most: for example, doctors disproportionately misdiagnose Black children with conduct disorders that are "often conflated with violent criminality"[87].

Given that states now mainly use a dangerousness standard[88], it is even more critical that psychiatric experts' testimony must surpass strong constitutional protections. If current psychiatric testimony cannot overcome a reasonable-doubt standard, researchers should instead develop more reliable and predictive ways for doctors to assess

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psychiatric diagnostic reliability in 2013 was no better than in the 1970's); Dale A. Albers et al., *Involuntary Hospitalization and Psychiatric Testimony: The Fallibility of the Doctrine of Immaculate Perception*, 6 Cap. U. L. Rev. 11, 16 (1976).

84. See Luis R. Marcos, *Taking the Mentally Ill Off the Streets: The Case of Joyce Brown*, 20 Int'l. Mental Health 7, 10–13 (1991); Judith L. Failer, *Who qualifies for Rights?* 11–28 (1st ed. 2002).

85. See Alexis Shaw, *Jodi Arias Defense Team Rests After 38 Days of Testimony*, ABC News. (April 16, 2013), available at https://abcnews.go.com/US/jodi-arias-defense-team-rests-38-days-testimony/story?id=18971855 (last visited November 17, 2021); Erin Fuchs, *Here's What We Know About Jodi Arias, who Finally Got Life in Prison for Killing her Ex-boyfriend*, Business Insider (April 13, 2015), available at https://www.businessinsider.com/jodi-arias-profile-2015-4 (last visited November 17, 2021).

86. See *Letter from Art Kobler to Affiliate & Nat'l Bd. Members*, ACLU (February 10, 1980).

87. See Nishar, *The Legacy Of "Deinstitutionalization"* (cited in note 82).

88. See Gordon, *The Danger Zone* at 660 (cited in note 75).

patients[89]. For example, experts could rely more heavily on suicide[90] and homicide risk scales, when assessing the patient's harm to himself or to others, instead of a patient's presentation. State legislatures could pass a consensus requirement, where agreement between a certain number of mental health experts about a person's mental illness and dangerousness would be a prerequisite to commitment. The Court should leave the issue of how to remedy varied diagnoses to legislators, who by nature of their role, are better equipped to inquire into the facts surrounding psychiatric expertise, diagnostic criteria, and relevant statistics.

Alternatively, the Court errs in *Addington* when it posits that the reasonable-doubt standard in criminal law applies to "specific, knowable facts," while psychiatric diagnoses are merely "filtered through the experience of the diagnostician"[91]. On the contrary, in criminal trials, which use a reasonable-doubt standard[92], doctors and other experts also come to conclusions colored by their own experiences[93]. Furthermore, experts in criminal trials have historically relied on unreliable science, like voice identification, bite mark forensics, and burn analysis[94]. If courts consider a jury well-equipped to use a reasonable-doubt standard for burn patterns, a jury should be equally well-equipped to use the same standard for psychiatric testimony.

So, adopting a reasonable-doubt standard protects patients from impressionistic psychiatric opinions and encourages research into more reliable expert testimony. Insufficiency of evidence is a reason

89. See Albers et al., *Involuntary Hospitalization and Psychiatric Testimony* at 13–15 (cited in note 83) (indicating that definitions of mental illness are vague, and experts must create clear definitions for psychiatric illness that they should then apply uniformly).

90. See Parvin Ghasemi et al., *Measurement Scales of Suicidal Ideation and Attitudes: A Systematic Review Article*, 5 Health Promotion Persp, 156 (2015) (providing an example of research on validating suicide risk scales).

91. See *Addington,* 441 U.S. at 430 (cited in note 1).

92. See *id.* at 421.

93. See Brandon L. Garret & Chris Fabricant, *The Myth of the Reliability Test*, 86 Fordham L. Rev. 1559, 1563 (2018).

94. See National Research Council, *Strengthening Forensic Science in the Science in the United States: A Path Forward* at 1, 42, 47, 173 (The National Academic Press, 2009), available at https://www.ojp.gov/pdffiles1/nij/grants/228091.pdf (last visited November 17, 2021).

to improve assessment, not to promote a lower burden of proof. The legislature should encourage better assessment, and the Court should still use a heightened burden of proof for psychiatric patients.

3. Conclusion

The Supreme Court's decision in *Addington* to adopt a "clear and convincing" burden of proof for involuntary psychiatric hospitalizations offered flimsy protection against civil commitment's severe curtailment of liberty.

Instead of a "clear and convincing" standard, the Court thus should have implemented a reasonable-doubt standard. First, a reasonable-doubt standard protects patients' freedoms. Second, it still allows states to exercise their parent and police powers. Finally, a reasonable-doubt standard accounts for unreliable psychiatric opinions.

At its core, the reasonable-doubt standard is a signaling mechanism. It flags the unique place involuntary civil commitment occupies in the law: a place where the State, relying solely on professional predictions, may withhold freedoms from a person who has committed no crime, and force his seclusion from the rest of the world. Given the gravity of such a situation, the reasonable-doubt standard reminds judges that they wield immense power and must use it wisely.

Though unreliable psychiatric assessments post a vexing problem, this problem is one for Congress, not the Court. In sum, judges must forcibly commit people who need the help – but only with proper proof.