

# Almost a Revolution: An International Perspective on the Law of Involuntary Commitment

Paul S. Appelbaum, MD

**To what extent have developments in commitment law around the world paralleled trends in the United States in the last three decades? Although the American emphasis on dangerousness criteria and stringent procedural rights has been echoed in a number of other countries, it has not dominated reform in most nations. The leading alternative has been the 1983 Mental Health Act in England and Wales, with its focus on the "health and safety" of the patient, as well as protection of other persons, and its avoidance of judicial hearings. How have these reforms fared? Extensive data from the United States, and more limited data from other countries, suggest that reforms in general are resisted when they are seen as shifting the focus away from patients' treatment needs. When law fails to reflect widely held moral sentiments, it is molded in practice to conform more closely to those sentiments. It is helpful to recognize that a variety of approaches to mental health law are consistent with reasonable protection of civil liberties in a democratic society. Greater attention to practices in other countries may help reformers expand the menu of options in policy debates.**

To what extent have developments in mental health law around the world paralleled trends in the United States in the last three decades? Have we been unique in the orientation that our statutes and jurisprudence have taken, or have we moved in directions common to all mod-

ern societies? This article explores the answer to these questions as they relate to one of the most important and contentious areas of mental health law: the law governing involuntary commitment of mentally ill persons.

In undertaking this task, I begin with a brief overview of the recent evolution of civil commitment law in the United States, before moving on to consider developments in other parts of the world. The portion of this article that portrays the situation in the United States draws heavily from the description and analysis in my book, *Almost a Revolution: Mental Health Law and the Limits of Change*.<sup>1</sup> The remainder of the article considers the

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Dr. Appelbaum is A. F. Zeleznik Distinguished Professor and Chair, Department of Psychiatry, and Director, Law and Psychiatry Program, University of Massachusetts Medical Center, Worcester, MA. This article is a revised version of the Manfred Guttmacher Award Lecture presented at the Annual Meeting of the American Psychiatric Association and the Semi-Annual Meeting of the American Academy of Psychiatry and the Law, New York City, May 1996. It was completed while the author was the Fritz Redlich Fellow at the Center for Advanced Study in the Behavioral Sciences, Stanford, CA. Address correspondence to: Paul S. Appelbaum, MD, Department of Psychiatry, University of Massachusetts Medical Center, Worcester, MA 01655.

extent to which the findings in that work are helpful in understanding changes in mental health law in other parts of the globe.

### Reform of Civil Commitment Law in the United States

From the formulation of the first statutes governing civil commitment to the new asylums in the early 19th century to roughly the mid-1960s, the focus of civil commitment law was unchanged and unchallenged: persons who were mentally ill and in need of treatment could be committed for that care. Moreover, although the degree of judicial oversight waxed and waned over time, the procedures by which commitment could be effected were often entrusted to medical hands. Whatever the legal procedures required, it was rare for them even to approximate the protections against incarceration associated with the criminal model.<sup>2</sup>

By the mid-1960s, however, the confluence of a number of trends brought the appropriateness of this approach into question. First, skeptics asked—in popular and scholarly literature alike—whether mental illness really existed, was a “myth,” or simply represented a higher state of consciousness.<sup>3,4</sup> Notions that mental disorder was simply a construct that allowed society to exercise social control over unpleasant but harmless deviant behavior attracted a great deal of support.<sup>5</sup> The idea of involuntary hospitalization for a disorder that might not exist was clearly problematic.

Second, even for those critics who did not doubt the existence of mental illness, available means of treating such disorders

seemed dubious. Exposés revealed abysmal conditions in many state hospitals, where the majority of chronically ill patients were hospitalized.<sup>6,7</sup> Sociologists and some psychiatrists suggested that long-term hospitalization *per se* might be the cause of many of the symptoms associated with chronic mental illness, representing a syndrome they called “institutionalism.”<sup>8,9</sup> Community-oriented psychiatrists simultaneously argued that patients could be better taken care of in their own communities, as outpatients when possible and as voluntary inpatients when not.<sup>10</sup>

Third, the civil rights revolution of the 1950s and 1960s reinvigorated theories of law that emphasized the rights of disenfranchised groups against the power of the government: first blacks, then prisoners, students, women, and persons with mental illness. The prevalent dissatisfaction with involuntary hospitalization of mentally ill persons was thereby channeled in a direction likely to result in change: into the courts.<sup>11</sup>

Finally, with budgets of departments of mental health accounting for the largest share of expenditures in many states—comparable to the position held by Medicaid today—legislatures were eager to embrace any option that, by making hospitalization more difficult to effect, offered the prospect of lower costs of care for persons with mental disorders.<sup>12</sup>

These forces, taken as a whole, culminated in a radical transformation of the law of civil commitment that essentially altered the *status quo* in every state in the nation over the course of 15 years (1964 to 1979). Use of involuntary commitment

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was limited to persons who were likely to be dangerous to themselves or others, the latter category including those so impaired as to be unable to meet their basic needs. The law allowing hospitalization of persons solely because they were “in need of treatment”—the historic standard of commitment in this country—was abandoned. In addition, a set of procedural rights was imported from the criminal law, including rights to a hearing, notice, representation by an attorney, to testify on ones’ own behalf, to call and cross-examine witnesses, and to exclude evidence that did not meet the ordinary standards of admissibility. Although states varied in the details of their statutes, the basic thrust of the reforms was similar in every state.<sup>13</sup>

Before considering the effects of these reforms, however, it may be useful to sketch out the parallel processes that were occurring elsewhere in the world, where similar pressures were leading other countries to rethink their approaches to commitment law.

### Reform of Civil Commitment Law Elsewhere in the World

Within a decade of the changes in commitment law in the United States, similar reforms began to be seen in other countries. They were often driven by related concerns about overuse of hospitalization, its cost, and its inherent limitation of individual rights. Often, reformers pointed explicitly to the United States’ experience as a model for their own proposals: sometimes because they believed that the United States was moving in the right direction; sometimes because they

felt impelled to be “modern” or “up-to-date,” which implied following the lead of the United States.

Among the countries that emulated the United States (I rely of necessity on the English-language literature here, whatever its shortcomings), to one degree or another, in adopting dangerousness-based commitment criteria were Austria,<sup>14</sup> Belgium,<sup>15</sup> Germany,<sup>15</sup> Israel,<sup>16</sup> the Netherlands,<sup>15, 17</sup> Northern Ireland,<sup>18</sup> Russia,<sup>15</sup> Taiwan,<sup>19</sup> and closer to home, Ontario, Canada.<sup>20</sup> Many more countries altered their commitment procedures to increase the procedural protections they afforded patients who were subject to involuntary hospitalization.

A good example of these American-style laws is the 1983 Mental Health Act in New South Wales, Australia, which demonstrates at the same time that other countries felt free to depart somewhat from the confines of the American model.<sup>21</sup> The basis for involuntary hospitalization under the New South Wales statute is limited to various formulations of danger to self or others, with some unique provisions. Danger to self, for example, includes the risk of financial harm, but only for persons who are manic. Curious about the motivation for including this provision, I asked an Australian colleague, who told me that the advocacy group for persons with bipolar disorders had lobbied for its adoption, seeking to prevent families of manic patients from being left destitute by patients’ spending sprees. Spendthrift schizophrenics, however, are not covered by its provisions.

Danger to others in the New South Wales statute includes not only the risk of

physical harm, but also harassment “so far beyond the limits of normal social behavior that a reasonable person would consider it intolerable.” This willingness to use involuntary hospitalization to protect the social milieu is decidedly not a provision of American statutes: witness the celebrated case of Larry Hogue, the homeless crack addict, subject to repeated psychotic episodes, who so terrorized the people living on and near West 96th Street in Manhattan.<sup>22</sup> Nor is New South Wales the only jurisdiction to take this approach. The new Israeli statute of 1991, for example, also allows commitment of mentally ill people with considerable impairment of reality testing or judgment, who cause severe mental suffering to others.<sup>16</sup>

Procedures in the New South Wales law draw heavily on formal legal due process. Although commitment can be effected by one physician if confirmed by a second, patients have the right to rapid review of their commitment by a magistrate at a full hearing, with mandatory legal assistance for the patient, and periodic review occurring before a Mental Health Review Tribunal after three months of hospitalization, and then every six months thereafter.

It would be a mistake, however, to assume that the American model, or even close variations of it, has become the dominant approach around the world. Although many countries have moved in the direction of better-defined commitment criteria and additional procedural protections, most have not turned to strict dangerousness-based statutes and criminal-style procedures to achieve those ends.

The 1983 Mental Health Act in England and Wales is perhaps the leading example of an alternative approach.<sup>23</sup> Interestingly, the momentum for reform in the United Kingdom came from a campaign led by a transplanted American civil liberties lawyer who pushed for adoption of an American-style model. Nonetheless, the criteria for commitment in the English statute require that patients be suffering from a mental disorder “of a nature or degree which makes it appropriate for [them] to receive medical treatment in a hospital,” and that admission is necessary for the *health and safety* of the patient or the protection of other persons. The term “health and safety” is interpreted to include mental health, thus allowing hospitalization when that is considered necessary for the treatment of patients’ psychiatric disorders.

Procedurally, there is no immediate mandatory review of physicians’ commitment decisions. Patients have the option to request postcommitment review, but studies suggest that only about 25 percent do so.<sup>24</sup> Review occurs automatically after six months of commitment and then every three years. The reviewing body, however, is a mental health tribunal (typically composed of a lawyer, a doctor, and a lay member) and not a court. Whatever we may think about the degree of protection afforded by the British statute (and I find troubling the absence of mandatory review soon after admission), there is no question that this statutory reform—motivated by the same kinds of considerations that drove the changes in the United States—follows a path very

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different from the American or New South Wales models.

Even a cursory review of recently enacted statutes in other jurisdictions, however, suggests that the British approach is more typical of international trends than is the more rigorous American model. For example, beginning our overview in Scandinavia, the Danish MH Act of 1989 allows commitment for dangerousness or to avoid deterioration of the prospect for recovery or improvement.<sup>25</sup> A guardian, who meets regularly with the patient, is appointed immediately, but judicial review occurs only on the patients' request. Norway's law is similar.<sup>15, 26</sup> Sweden's 1992 statute permits hospitalization when a serious mental disturbance results in an "absolute need for full-time psychiatric care."<sup>15, 27</sup> Court review occurs after four weeks. Finland's 1990 law requires finding that, for a patient to be committed, the patient's condition will deteriorate if left untreated, or the patient's own health or the safety of others will be seriously endangered.<sup>28</sup> Hospitalization is permitted for three months before court review.

Elsewhere in Europe, the 1990 statute enacted in France allows hospitalization on the physician's discretion for persons in need of treatment and relegates decisions about commitment for dangerousness to the prefect of police (with physician review).<sup>15</sup> Switzerland allows "detention in the interest of the patient's welfare," when "the necessary personal care is otherwise not guaranteed."<sup>29</sup> Greece's 1992 law has the criterion of incapacity to judge one's own health interests and requires that a failure to commit would lead to an inability to treat or to

deterioration (as well as danger to self or others).<sup>30</sup> Italy, which undertook Europe's most radical reform of a mental health system in 1978, permits confinement when urgent intervention is required, treatment is being refused, and there is no less restrictive alternative.<sup>31</sup> Interestingly, dangerousness is explicitly rejected as a basis for commitment because of its stigmatizing effect on persons with mental illness. Ireland's government is now proposing a new commitment statute that would permit commitment for impaired judgment leading to serious deterioration or a failure to receive appropriate treatment, as well as for dangerousness.<sup>32, 33</sup>

Trends are similar outside of Europe, although considerable variation can be seen from country to country. Japan's 1988 Mental Health Act requires dangerousness as a basis for commitment if hospitalization is initiated by the authorities, but if a responsible family member consents to admission, all that is required is that the patient be mentally disordered and in need of hospitalization.<sup>34</sup> One glimpses in this distinction Japan's traditional reliance on the family as the primary locus of decision making for its members. In India, involuntary hospitalization can be accomplished on the application of a relative or friend of the patient, if two doctors concur that it is necessary for the interests of the mentally ill person, whose condition must be amenable to treatment.<sup>35</sup>

Australasia, apart from New South Wales, has tended to favor English-model approaches. New Zealand permits commitment for a serious danger to the health

or safety of the patient or others, or seriously diminished capacity to care for self.<sup>36</sup> In Australia, the Northern Territory, South Australia, Queensland, and Victoria employ criteria focused primarily on the patient's need for treatment; in contrast, the Capital Territory utilizes dangerousness-based criteria.<sup>37</sup>

To summarize, the 1980s and 1990s have witnessed an unprecedented wave of reform in commitment laws around the world, partially in response to the same forces that resulted in reforms in the United States a decade or more earlier, partially driven by the American actions themselves. Although most changes were aimed at more clearly defining the populations eligible for commitment and providing some oversight of physicians' decisions, most countries have not gone as far with either of these initiatives as have almost all jurisdictions in the United States.

### The Consequences of Reform

What happened as a result of the reforms in the United States and other countries? Characterizing legal reforms is relatively straightforward. Identifying their actual impact is somewhat more complex. There is no question as to the expectations of most persons in the United States, at least when the reforms of late 1960s and 1970s were enacted. The reformers themselves sought a drop in the number of persons susceptible to civil commitment and a shift in their characteristics to a more impaired group of patients, who placed themselves and others at clear risk of harm.

Opponents of the reforms, including

many, but by no means all, psychiatrists, agreed that this was likely to occur, differing only on the desirability of the changes. The "battle cry" of the skeptics was coined by Wisconsin psychiatrist Darryl Treffert, who maintained that patients who could no longer be committed were "dying with their rights on" because of the new laws.<sup>38</sup> Commenting on the best known of the court decisions striking down the older generation of statutes, in the federal district court opinion in *Les-sard v. Schmidt*, Alan Stone maintained that "if followed exactly, [it would] put a virtual end to involuntary confinement."<sup>39</sup>

How well were these expectations reflected in reality? We can sum up the considerable data on the effects of the new civil commitment statutes by saying that it has been much more difficult than anyone anticipated to demonstrate significant and persistent changes in commitment practices as a result of the new laws. Three bodies of data are relevant here.

First, more than two dozen studies have been performed of changes in commitment rates before and after reform.<sup>1</sup> A few studies showed marked drops in the rate of commitment when new statutes replaced need for treatment with dangerousness criteria and implemented new, stricter procedures. This is what both proponents and critics of the reforms expected. An even larger number of studies, however, demonstrated no change in commitment rates as a result of the reforms (although in many states rates of commitment had been declining for some years and continued to do so).

How could these two sets of data be

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reconciled? Two Canadian psychologists, Bagby and Atkinson,<sup>40</sup> offered a way out of the dilemma. They noted that when follow-up periods were limited to the immediate postreform era, often one year, sharp drops in commitment rates were found. But researchers who extended their data collection beyond the first year almost invariably found a rise in commitment rates, in some cases a return to or increase above pre-reform levels. Thus, although the Bagby and Atkinson analysis does not imply that commitment law reforms had no impact—indeed it suggests the opposite—it does indicate that the impact was much less than expected and in most cases faded over time. I will return later to what might have accounted for this phenomenon.

A second way of assessing the effect of changes in commitment law is to see whether the nature of committed populations was altered in the expected directions: did they become sicker and more dangerous to self and others after the reforms? Of the many studies of this type, I have not been able to find one that demonstrates significant changes in the characteristics of committed populations.<sup>1</sup> Demographically and diagnostically, the groups look the same before and after reform. Of even greater interest, the post-reform groups appear to be no more likely to meet the new commitment criteria than the groups committed prior to the changes in the law. These findings add to the evidence suggesting that there might be less going on with commitment reform than first meets the eye.

The final way to assess the impact of new commitment laws is to attempt to

identify those patients who are in need of treatment (and therefore eligible for commitment under the old criteria), but not dangerous, and thus now must be turned away from care. These are the patients whom Treffert feared were “dying with their rights on.” One group of researchers led by Mulvey and Lidz in Pittsburgh,<sup>41</sup> reviewed 390 psychiatric emergency room patients and found only one person who was rated as being in need of immediate treatment, resisting that treatment, and not eligible for commitment under the Pennsylvania statute. In the end, she was committed anyway. A second study, by Segal and colleagues in California,<sup>42</sup> found a strong correlation in their 251 cases between severity of symptoms and indicators of dangerousness. They argued that the group about which many critics of the new laws were worried, very ill, but nondangerous patients, did not appear to exist in any substantial numbers.

Thus, the changes expected as a result of the new laws have been exceedingly difficult to document. Although rates of commitment fell in many states, they reflected a preexisting pattern related to the shutdown of state facilities and a shift to community care. When new commitment statutes accelerated this process, the greater part of the effect was temporary. Further, although a review of the relevant data would go beyond the scope of this article, it appears that the decrease in public sector psychiatric beds, rather than changes in the law, accounts for the limitations most often faced by mental health professionals in attempting to hospitalize patients in need of care. Clearly, something is happening in the United States to

modify the expected impact of commitment law reform.

Before considering what processes might account for these unanticipated findings, we need to note the difficulty in drawing conclusions about the effect of commitment law changes in other countries. Several factors are relevant here. First, the international reforms are much more recent than those in the United States. Sufficient time may not have passed in many countries for studies like the American ones to have been performed. Second, it seems clear that the cottage industry of empirical studies of commitment that was spawned in the United States in the 1970s and 1980s has not developed in most other countries, probably because resources for these policy-oriented investigations are much more limited. (Of course, some studies may exist in foreign language journals and thus be inaccessible to this review.)

Thus, with only a few exceptions (e.g., there are data suggesting no consistent change in rates of commitment after changes in the law in Austria),<sup>14</sup> we lack data on the impact of the laws on the rates of commitment and the nature of committed populations. As we shall see, however, there are reasons to suspect that limitations similar to those in the United States on the extent of changes induced by the new laws may obtain in other countries as well.

### **Civil Commitment in Practice**

How can we explain the relative lack of impact of commitment law changes in the United States, and do the explanatory processes seem to occur in other countries

as well? The key to understanding the difference between commitment law on the books and commitment law in practice is to recognize that laws are not self-enforcing. Indeed, implementation of involuntary hospitalization is delegated to a variety of participants in the commitment process, all of whom have the potential to affect how the law is applied. When the results of a law narrowly applied will be contrary to the moral intuitions of these parties, they will act at the margins to modify the law in practice to achieve what seem to them to be more reasonable outcomes.

This process is easiest to see in the behavior of judges and other nonclinical decision makers involved in the commitment process. In an observational study of a California commitment court, sociologist Carol Warren found that the judge applied "commonsense" notions to his decisions.<sup>43</sup> That is, he believed that crazy people who were likely to be helped by treatment should be in the hospital, even if the narrow terms of California's commitment statute were not met. Similarly, in North Carolina, Hiday and Smith<sup>44</sup> found that in 47.5 percent of commitment cases in which the petition lacked any information concerning the statutory dangerousness criteria, respondents were committed anyway.

Clearly, this tendency is not limited to the United States. Several observers in England<sup>45-47</sup> have noted that mental health review tribunals often behave paternalistically, with decisions frequently turning not on whether patients meet commitment criteria, but on whether, if released, they will cooperate with treat-



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ment in the community. (Although a substantial percentage of appeals—up to 20% in three series cited by Wood<sup>45</sup>—result in release, these are not reviews of acute hospitalizations, but decisions concerning whether to continue to hold patients after several months of hospitalization. The same is true of a similar study of release decisions in New Zealand.<sup>36</sup> Release decisions, therefore, may reflect patients' readiness for discharge rather than their failure to meet commitment criteria.) Likewise, in Norway, an independent review of 212 patients whose commitments were upheld by a review board found that about 15 percent of these decisions seemed not to meet even that country's broad commitment criteria ("necessary to ensure recovery or improvement").<sup>48</sup>

We can understand these results as indicating that decision makers, including judges, have intuitive criteria for involuntary commitment that they apply even when a narrow reading of the law might lead them elsewhere. Note that this does not mean that all respondents get committed—they do not—or that the law gets ignored—it does not. But at the margins, when the outcome would be troubling, the law is bent to accommodate judges' moral sense.

Surprisingly, perhaps, lawyers representing patients at commitment hearings often seem to behave in a similar fashion. Poythress, who trained attorneys in Texas on how to challenge expert testimony at commitment hearings, found that none of them used the training, because they did not see it as their job to achieve the release of people whom they viewed as

genuinely ill.<sup>49</sup> Warren's observational study in the California courts resulted in similar findings: attorneys were often not playing the adversarial role anticipated by the law.<sup>43</sup> Again, the phenomenon is not limited to the United States. Bottomley<sup>50</sup> in Australia noted that many lawyers there elect to argue for their version of patients' needs rather than for patients' expressed wishes to be released. Lawyers' presence, he concluded, does not guarantee an adversarial proceeding.

With judges and lawyers, who are trained to be respectful of individual rights, bending the law when that seems to be necessary for patients to receive treatment, it is no surprise that psychiatrists, whose primary interest is in providing treatment, do the same. Reviews of commitment petitions completed by psychiatrists and other mental health professionals routinely reveal a failure to specify legally required criteria in a large percentage of cases: 16.1 percent in a North Carolina study of cases that led to judicial commitment<sup>44</sup>; even higher numbers in a set of Canadian studies.<sup>51, 52</sup>

One might wonder whether these findings merely reflect sloppy completion of the forms, but chart reviews attempting to document the presence or absence of commitment criteria, regardless of whether they are recorded on commitment forms, have found similar results. Hoyer<sup>53</sup> showed that Norway's criterion allowing commitment when necessary to ensure recovery or improvement was frequently used in cases when deterioration (not covered by the statute) was feared. A Finnish study<sup>28</sup> revealed that the mental illness criterion, interpreted as requiring

that patients be psychotic, was not clearly met in 20 percent of involuntary admissions. These were largely cases in which patients were suicidal or in which psychosis was suspected but not proven and in which it was believed that treatment would be helpful. Similarly, in California after the implementation of the Lanterman-Petris-Short Act in 1969, a study by the ENKI research group<sup>54</sup> found that between 21 and 53 percent of patients committed (depending on jurisdiction within the state) failed to meet commitment criteria.

How do mental health professionals accomplish these commitments? Many studies have pointed to the flexibility inherent in the “grave disability” or “unable to care for self” provisions of most commitment laws. Researchers in Pittsburgh<sup>41</sup> found that almost all persons who are deemed greatly in need of treatment, but who are not overtly dangerous to themselves or others, are committed on this basis. Indeed, a Georgia study<sup>55</sup> suggested that mental health professionals may help coach patients’ family members on how to describe their behavior, thus accounting for the changes in these descriptions recorded in commitment applications as commitment law changed.

### **Lessons from the Revolution That Wasn’t**

What can we learn from the revolution that wasn’t—the sweeping changes in commitment laws in this country, and to a lesser extent around the world, that made much less of a difference than anyone had

expected? First, insofar as law fails to reflect widely held moral sentiments, it is subject to being molded in practice to conform more closely to those sentiments. This seems to be particularly the case for mental health law; in my book I suggest that responses to changes in the law regulating the right to refuse treatment and the insanity defense can be understood similarly.<sup>1</sup>

When commitment law in the United States changed from a need-for-treatment orientation to a focus on the prediction and control of dangerous behavior, it threatened to violate the commonsense intuitions of the majority of the population that severely mentally ill people who could be helped by treatment should receive treatment, even if it must be provided against their will. In part, this divergence between legal reform and generally held moral sentiments represented the capture of the policy-making apparatus in the courts and legislatures by persons whose view of mental health law was dominated by skepticism regarding the reality of mental illness, the pain it produced in patients, the effectiveness of treatment, and the degree of trust that could be placed in psychiatrists and other mental health professionals.

After an initial period of adaptation, during which the rules were interpreted narrowly and commitment rates in many jurisdictions declined, all those involved in the commitment process—judges, lawyers, mental health professionals, and family members—found mechanisms to make the outcomes of the process more nearly identical to their moral intuitions.

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This process is by no means unique to mental health law. It can be seen in America's reaction to prohibition as well as in our current ambivalence about mandating the use of seat belts in cars.

Moreover, although the data are skimpy at this point, it appears that this reaction is not unique to the United States. When commitment law in Europe, Australia, and elsewhere became more restrictive than public sentiment could endorse, similar responses were seen among all participants in the process. The similarities are particularly striking given the differences in "set point" for the statutes; that is, reforms that seem modest by American standards nonetheless evoked strong responses from people in countries unaccustomed even to that degree of limitation on their abilities to confine persons for treatment.

Second, assuming this analysis is accurate, it suggests that there are good reasons to avoid taking extreme positions, especially those motivated by ideological purity, in developing mental health law. Inherently, mental health law involves the compromise of conflicting interests, often, as noted here, interests in providing treatment to those who are suffering posed against interests in protecting the liberty of persons to make decisions about their own care. When a balance is struck that fails to reflect a social consensus, the result is what I have described here: law on the books that bears little resemblance to law in practice. It is arrogant to assume that widely held values do not reflect some truth that ought to be taken into account in the policy-making process, not

only because failing to do so will defeat the purpose of reform, but also for the intrinsic value of achieving a just compromise. Compromise should be considered the goal, not the second-best outcome, of policy formulation in mental health law.

Third, I would like to suggest that there is wisdom in the maxim that "travel broadens one's horizons." As we struggle to fashion mental health law in the United States, there is a strong tendency for us to succumb to the belief that only American experiences can be relevant; we have nothing to learn from the rest of the world. The general belief in America's absolute uniqueness contributes mightily to our tendencies toward solipsism, often resulting in a much constricted domain of choices from which we make policy. This survey of law around the world suggests that there are a variety of approaches to the substantive and procedural conundra of civil commitment that are consistent with reasonable protection of civil liberties in a democratic society. Indeed, some of the countries that share most closely in our legal traditions, including Britain and other members of the Commonwealth, have chosen very different approaches to commitment law. As we think about the future evolution of our own statutory approaches, we might keep this expanded menu of options in mind.

There is, I think, a final word of wisdom here. Not everything that comes advertised as a revolution turns out to be one. De Toqueville was right; one ought not to underestimate the power of the *ancien regime*.

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