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NEW STANDARDS FOR THE INVOLUNTARY COMMITMENT OF THE MENTALLY ILL: "DANGER" REDEFINED

Elizabeth A. McGuan*

"Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent."1
- Justice Louis D. Brandeis

INTRODUCTION

Mrs. H., aged seventy-five, had managed her mental illness successfully for many years. Following the death of her husband, however, she became increasingly anxious and tearful. She began to withdraw from the social activities she had previously enjoyed and to spend more time alone. She lost weight and began to have trouble sleeping. In the year following her husband's death, her thinking became disordered; she began forgetting names, missing appointments, and misplacing objects. On several occasions, she was convinced she saw her husband in their home.2 Her adult children noticed the

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* J.D. candidate, May 2010, Northern Illinois University College of Law, B.A., December 1982, the University of Michigan. Thank you to Professor Lawrence Schlam, Professor Emeritus Jeffrey Parness, and Legal Writing Instructor Meredith Stange for their expert advice, attorneys Joseph Monohan for suggesting the topic, Andy Norman for his insightful comments, and Suzanne Cahalan for updates on the impact of the amendment on practitioners. Sincere thanks to Teresa Berge of the Illinois Guardianship and Advocacy Commission for both her legal analysis and her persistent encouragement.

changes in her and became concerned that her mental illness was out of control. They encouraged her to seek medical attention, but she resisted them because she did not think anything was wrong. When they tried to get her help against her will, they were turned away because she did not meet the standard for involuntary commitment. Her family could only stand by and watch her disease progress, knowing that without treatment she faced an increased risk of suicide, substance abuse, homelessness, and criminal victimization.

Now, consider a different outcome. Assume Mrs. H.'s children insist she see her doctor, a general practitioner in her community. Because he has not received specialized training in the diagnosis of mental disorders in the elderly, he misdiagnoses her normal grieving, early dementia, and moderate depression as a psychiatric emergency and signs a petition for her involuntary commitment in a mental hospital.

3. The standard is mentally ill and dangerous to self or others. See O'Connor v. Donaldson, 422 U.S. 565, 575 (1975).


6. When applied to the elderly, the term "mental disorder" includes both psychiatric illnesses (such as schizophrenia) and cognitive disorders (such as dementias). See generally KENNETH SAKAUYE, GERIATRIC PSYCHIATRY BASICS 95 (2008) (noting that some depressive disorders cause memory problems severe enough to appear as cognitive disorders); id. at 95 (explaining that mental illness and dementias may occur simultaneously); BUTLER ET AL., supra note 2, at 125 (discussing the psychological or behavioral changes that frequently accompany cognitive disorders in the elderly, including paranoia and aggressive impulses); id. at 235 (providing the extensive list of physical illness and medications which cause symptoms of mental disorders in the elderly).
Her life will change dramatically. She will be kept behind a locked door. Her autonomy will be removed: other people will tell her when to get up, when to shower, when to eat, when to sleep, and what to wear. She will be subject to whichever treatments are currently in vogue with the psychiatric community and which today consist of electroconvulsive therapy (ECT) and medication with psychotropic drugs that have serious, long-term side effects. She can be subjected to seclusion, chemical restraints, and even mechanical restraints.

7. "The vulnerability of the aged to death or illness as a result of changing their living arrangements (called 'moving trauma' or 'transfer mortality') is a serious cause for concern." BUTLER ET AL., supra note 2, at 313.


9. Id.

10. "During the last decade, the 'typical' ECT patient has changed from low-income males under forty, to middle-income women over sixty-five." Mike E. Jorgensen, Is Today the Day We Free Electroconvulsive Therapy?, 12 QUINNIPIAC HEALTH L.J. 1, 5 n.13 (2008).


12. SAKS, supra note 8, at 122. "Seclusion involves locking someone in a small, bare room that is devoid of anything that could be used to hurt oneself or others." Id. The Illinois statute regulating seclusion is codified at 405 ILL. COMP. STAT. 5/2-109 (2005).

13. SAKS, supra note 8, at 167. "Patients . . . can be given heavy doses of medication that will restrain them chemically; at the limit, patients can be made to fall asleep." Id. at 164. Illinois statute permits the use of emergency medications for serious and imminent physical harm, which are essentially chemical restraints. 405 ILL. COMP. STAT. 5/2-107(a) (2005).

14. SAKS, supra note 8, at 147.

Staff suggest that she needs to be restrained. When Julia resists, six orderlies converge on her, pin her to the bed, and, despite her struggles,
Many people prefer jail to a mental hospital because "prisons have gyms, libraries, long periods of private time, paid employment, better employability after release, and many other advantages . . . ." Many people also "prefer the greater freedom from observation in a jail." And finally, "[t]hey may feel that it is more stigmatizing to be a mental patient than a criminal." To be labeled "mentally ill" means to be included in a group that has been viewed with aversion and fear throughout history. These attitudes were reflected in laws in place during the early part of the twentieth century which forbid the mentally ill to marry and could subject them to compulsory sterilization.

When enacting civil commitment statutes, state legislatures must somehow balance these two competing interests: the interest of the state in protecting the mentally ill person from the danger he poses to himself, and the interest of the mentally ill person in avoiding involuntary confinement. While all

cuff her limbs with thick leather straps. Finally, they immobilize her torso with a body net. Tied spread-eagle to the bed, unable to move, Julia is now in "six point" restraints. In time Julia's physical pain will increase. . . . Although she will beg for release . . . Julia will neither be let go, nor told when staff plan to untie her. Alone, frightened, and in pain, she will begin to struggle again—a signal to staff that she needs to be restrained longer . . . . A significant number [of patients] die in restraints, typically because they aspirate their vomit and choke to death or have a heart attack. One study identified 142 deaths reported as occurring during or immediately after restraint between 1989 and 1999. A research specialist at the Harvard Center for Risk Analysis estimated many more unreported deaths—50 to 150 each year.

Id. at 146-47; the Illinois statute regarding restraints is codified at 405 ILL. COMP. STAT. 5/2-108 (2005).
15. SAKS, supra note 8, at 54, 71-72.
16. Id. at 72.
17. Id.
18. See Laura E. Hortas, Asylum Protection for the Mentally Disabled: How the Evolution of Rights for the Mentally Ill in the United States Created a "Social Group," 20 CONN. J. INT'L L. 155, 159 (2004). In addition to the stigma of being mentally ill, the elderly mentally ill also face "ageism," which is defined as "prejudice towards, stereotyping, or discrimination against persons based solely on chronological age . . . ." Williams, supra note 5, at 443.
19. Hortas, supra note 18, at 159. Thirty states enacted compulsory sterilization laws. Id. As recently as the 1920s, consistent with Hitler's extreme position of the eugenics movement, state legislatures in the United States were considering the idea of killing the mentally ill. Id. at 160.
20. The state's interest in preventing the danger the mentally ill person may
segments of society are impacted by involuntary commitment statutes, because the elderly (defined as those over age sixty-five) suffer mental illness at a higher rate than the general population, they are impacted by the statutes at a proportionally higher rate.\textsuperscript{21} In addition to the fact that they suffer mental illness at a higher rate, there are simply more elderly now than there have been at any time in the past.\textsuperscript{22} And finally, the elderly are the most rapidly growing segment of the population.\textsuperscript{23} When the seventy-six million baby boomers turn sixty-five (between the years 2010 and 2030) the number of elderly will increase significantly.\textsuperscript{24} By the year 2050, it is estimated there will be eighty-six million elderly;\textsuperscript{25} if they experience mental illness at a standard rate, there will be 17.2 million mentally ill elderly in the United States.\textsuperscript{26}

Over the past twenty years, legislatures in a number of states have amended their involuntary commitment statutes to pose to others is beyond the scope of this note.

\textsuperscript{21} AAGP, supra note 5. Nearly 20% of the elderly “experience mental disorders that are not part of normal aging.” Id. Additionally, the highest suicide rate in America is among those aged sixty-five and older. BUTLER ET AL., supra note 2, at 100. The many factors behind the higher rate of mental illness in the elderly are beyond the scope of this note.

\textsuperscript{22} BUTLER ET AL., supra note 2, at 7. Factors behind this trend include improved medical care and a drop in birthrate. Id. at 6.

\textsuperscript{23} Williams, supra note 5, at 442.

\textsuperscript{24} AAGP, supra note 5.

\textsuperscript{25} Helen Y. Kim, Do I Really Understand? Cultural Concerns in Determining Diminished Competency, 15 ELDER L.J. 265, 268 (2007). However, the rate of mental illness in the elderly is expected to increase. “With the overall rise in longevity, there will be an increasing number of new cases of late-life psychosis as well as an increasing number of patients who developed psychosis in adolescence or young adulthood and will be living into old age.” Dilip V. Jeste, Strengths and Limitations of Research on Late-Life Psychoses, in EMERGING ISSUES IN MENTAL HEALTH AND AGING 72, 75 (Margaret Gatz ed., 1995). Also, “[t]he extent of posttraumatic stress disorder [(PTSD)] among elderly people . . . is only beginning to be appreciated.” It is possible that Vietnam War veterans will experience PTSD and major depression as they age. Lon S. Schneider, Efficacy of Clinical Treatment for Mental Disorders Among Older Persons, in EMERGING ISSUES IN MENTAL HEALTH AND AGING 19, 20-21 (Margaret Gatz ed., 1995).

\textsuperscript{26} Providing care for such a large percentage of the population will have a significant impact on society as a whole. “Mental disorders . . . produce an economic burden that includes direct treatment costs, loss of productivity, expenditures for public assistance, family and caregiver burden, and legal costs.” Jeste, supra note 25, at 89-90.
allow for the more aggressive commitment of the mentally ill. This note analyzes a typical statute, an amendment to the Mental Health and Developmental Disabilities Code, approved by the Illinois General Assembly in September 2007, using it as a paradigm for similar statutes throughout the United States. This note discusses whether the amendment, which redefined "dangerous conduct," deprives a mentally ill person of a fundamental liberty interest guaranteed by the Constitution. It begins with an overview of mental health law in the United States since World War II. An analysis of the constitutionality of the amendment follows, looking specifically at issues of vagueness, whether the amendment comports with Supreme Court precedent regarding the requirement of danger, and whether it uses a medical or legal standard for commitment. It then analyzes arguments made in favor of the amendment and discusses whether it is possible to modify the amendment to bring it in line with Supreme Court precedent. Finally, this note will look at some of the possible consequences of the amendment as written.

**HISTORY OF MENTAL HEALTH IN THE UNITED STATES**

In the decades following World War II, psychiatric hospitals were "over-crowded, filthy, warehouse-like institutions." Conventional treatments for mental illness consisted of isolation, hydrotherapy, insulin coma therapy, convulsive therapies, and lobotomies. "[A]nyone who was adjudged suffering from a mental illness could be involuntarily placed in treatment, often with no more than two physicians signing a certificate." Mental health care was based solely on a medical standard: if a

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27. See Scherer, supra note 4, at 362-63.
29. Davoli, supra note 4, at 160.
30. Scherer, supra note 4, at 363-64.
person was determined to have a mental illness, he had no right to refuse commitment or treatment.\textsuperscript{32}

A number of factors contributed to a fundamental change in the delivery of mental health services in the United States in the 1950s and 1960s.\textsuperscript{33} The process, which came to be known as "deinstitutionalization," consisted of "the movement of patients from state psychiatric hospitals to alternative community-based facilities."\textsuperscript{34} First among these factors was the discovery in the 1950s of medications to control mental illness;\textsuperscript{35} chlorpromazine, the first antipsychotic drug, was marketed in the United States in 1954.\textsuperscript{36} Second, sociological studies began to expose the conditions that existed in the institutions.\textsuperscript{37} Third, public interest and civil rights lawyers began to challenge some of the mental health practices in use at the time, including the standards and procedures for involuntary commitment.\textsuperscript{38} In cases such as \textit{Lessard v. Schmidt}, courts compared "civil commitment to criminal confinement and deemed it constitutionally defective unless it incorporate[d] due process protections such as notice to the . . . patient of the reasons . . . for confinement, a right to counsel, a right to a jury trial, and consideration of less restrictive alternatives."\textsuperscript{39} In its landmark decision, \textit{O'Connor v. Donaldson}, the Supreme Court held "a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."\textsuperscript{40} Recognizing the liberty interest

\begin{itemize}
\item \textsuperscript{32} Erickson et al., \textit{supra} note 4, at 364.
\item \textsuperscript{33} Nancy K. Rhoden, \textit{The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory}, 31 EMORY L.J. 375, 378 (1982).
\item \textsuperscript{34} \textit{Id.}
\item \textsuperscript{35} \textit{Id.} at 378-79.
\item \textsuperscript{36} \textit{Id.} at 379.
\item \textsuperscript{37} \textit{Id.} at 380.
\item \textsuperscript{38} \textit{Id.} at 385-86.
\item \textsuperscript{40} \textit{O'Connor v. Donaldson}, 422 U.S. 563, 576 (1975).
\end{itemize}
involved, the Court then increased the state's burden of proof from a "preponderance of the evidence" to "clear and convincing evidence." With these rulings, commitment based solely on a medical standard came to an end. The Court added to the state's burden a requirement that the legal standard of dangerousness be shown as well.

Finally, "whether . . . economic motives were the primary impetus for deinstitutionalization, they clearly played a critical role." In 1965, when the federal government enacted the Grants to States for Medical Assistance Program, known as Medicaid, which was "designed to improve healthcare for the poor by providing matching funds for state expenditures," it excluded psychiatric care provided in state-funded psychiatric hospitals. This exclusion created a major incentive for states to reduce the number of institutionalized patients and to close psychiatric hospitals altogether.

Regardless of the reasons, state and federal governments moved from a hospital-based setting to a community-based setting for the delivery of mental health services. The governments failed, however, to provide funding to the community to support the increased population of mentally ill persons who received care there. Because of the limited availability of medical care in the community, the 1970s and 1980s became periods of "transinstitutionalization," as the mentally ill moved from hospitals to jails, or to "open air

42. O'Connor, 422 U.S. at 576.
43. Rhoden, supra note 33, at 382.
44. Davoli, supra note 4, at 163.
45. Id. at 170.
46. Rhoden, supra note 33, at 378.
47. Id. at 392.
48. See Saks, supra note 8, at 1. "[I]n 1983, in Oxford England—a city of 125,000—there were forty-three group homes for deinstitutionalized patients. In New Haven, Connecticut—also a city of 125,000—in that same year there was one halfway house." Id.
49. Rhoden, supra note 33, at 391.
asylums"—the streets.\textsuperscript{50}

By the 1980s and 1990s it had become clear that the health care system in the United States was not meeting the needs of the mentally ill. A large number of the mentally ill were not receiving care of any kind.\textsuperscript{51} Their families could not force them into treatment against their will because they did not reach the statutory threshold for involuntary commitment.\textsuperscript{52} And finally, many mentally ill persons were becoming trapped in a cycle that became known as the "revolving door syndrome," in which they deteriorated seriously enough to warrant involuntary commitment, were hospitalized just long enough to become stable, and were released back into the community, where without the resources to maintain their recovery, they began to deteriorate again.\textsuperscript{53} In response to these concerns,\textsuperscript{54} legislatures across the country began to revise their involuntary commitment statutes to permit for the more aggressive commitment of the mentally ill.\textsuperscript{55}

**SENATE BILL 234**

The Illinois General Assembly was among those state legislatures that amended its mental health code to lower the standards for involuntary commitment.\textsuperscript{56} Legislative hearings

\textsuperscript{50} Davoli, *supra* note 4, at 160.

\textsuperscript{51} See *id.* at 159.

\textsuperscript{52} Scherer, *supra* note 4, at 367. The standard under the preexisting statute in Illinois was "reasonably expected to inflict serious physical harm upon himself or herself or another . . . ; or . . . unable to provide for his or her basic physical needs so as to guard . . . from serious harm." 405 ILL. COMP. STAT. 5/1-119 (2005).

\textsuperscript{53} Rhoden, *supra* note 33, at 390-91.

\textsuperscript{54} A number of highly publicized acts of violence by mentally ill people also served as an impetus for what led the government to determine the system in play was not working; however, "contrary to popular belief, many scientific studies have struggled to find a concrete link between violence and severe mental illness." Scherer, *supra* note 4, at 377; see SAKS, *supra* note 8, at 50 ("Most of the evidence suggests that, with the exception of certain categories such as psychopathy, mentally ill people . . . are only modestly more likely than the general public to be dangerous.")

\textsuperscript{55} State legislatures also began to pass Involuntary Outpatient Commitment Statutes as a way to address these issues. Scherer, *supra* note 4, at 362-63.

\textsuperscript{56} 405 ILL. COMP. STAT. 5/1-119 (2005).
indicate the representatives lowered the standard in order to address two specific problems. First, many mentally ill persons did not seek help voluntarily because they were unaware they had a disease. Second, the standards for involuntary commitment were too high to allow families to get their loved ones help before they had completely deteriorated. Senate Bill 234, which went into effect June 1, 2008, made three changes to the preexisting statute regulating involuntary commitment.

First, Senate Bill 234 added a new category of persons subject to involuntary admission:

A person with mental illness, who, because of the nature of his or her illness, is unable to understand his or her need for treatment and who, if not treated, is reasonably expected to suffer or continue to suffer mental deterioration or emotional deterioration, or both, to the point that the person is reasonably expected to engage in dangerous conduct.

Second, a new section was added, which defined dangerous conduct as "threatening behavior or conduct that places another individual in reasonable expectation of being harmed, or a person's inability to provide, without the assistance of family or outside help, for his or her basic physical needs so as to guard himself or herself from serious harm."

Finally, the section was deleted that read "a person with mental illness and who because of his or her illness is reasonably expected to inflict serious physical harm upon himself or herself or another in the near future." It was replaced with the language "a person with mental illness and who because of his or her illness is reasonably expected to engage in dangerous

58. Id.
59. Id. at 209.
62. Id.
63. Id.
conduct."  

The new language removed the requirement that the harm be serious, physical, or expected to occur in the near future.  

ANALYSIS OF THE AMENDMENT  

EXPLANATION OF DUE PROCESS  

With this amendment, the Illinois legislature changed the standards under which the state was permitted to deprive the mentally ill of their liberty. In the United States, the government may infringe on such a fundamental right to the extent it furthers a compelling state interest. However, when the government infringes on such an interest, an individual has the right to challenge the state action under the Fifth and Fourteenth Amendments of the Constitution, which provide that the government cannot deprive any person of life, liberty, or property without due process of law. In order for the law to satisfy the Constitution, then, the court must determine if due process was satisfied; if the court finds that due process was satisfied, it upholds the law, if it finds it was not, the law is struck down. In their determination of whether due process is satisfied, courts are limited to considering whether the statute violates some specific constitutional provision; courts are not permitted to evaluate the merits of the legislature's economic, social, or political policy choices.

There are two components to due process. Substantive

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64. Id.
65. Id.
66. See generally id.
due process asks whether the government has an adequate reason for taking away a person's life, liberty, or property.\textsuperscript{71} Procedural due process refers to the procedures the government must follow before acting, such as requirements for notice and an opportunity to be heard.\textsuperscript{72} To determine if a statute satisfies substantive due process, the court looks first at the liberty interest involved.\textsuperscript{73} If the interest is minimal, courts use the "rational basis test."\textsuperscript{74} To satisfy the test, the statute need only bear a rational relationship to a legitimate state purpose and be neither arbitrary nor discriminatory.\textsuperscript{75} Under a rational basis test, the statute carries a presumption of constitutionality;\textsuperscript{76} the person challenging the statute has the burden of proof (by a preponderance of the evidence)\textsuperscript{77} that the statute is unconstitutional.\textsuperscript{78} If, however, the challenged legislation impinges upon a fundamental right,\textsuperscript{79} the court will examine the statute under the "strict scrutiny" standard to determine whether it comports with due process.\textsuperscript{80} To satisfy this standard, the statute must be necessary to achieve a compelling state interest.\textsuperscript{81} Additionally, under strict scrutiny, the burden is placed on the state to prove that the law is constitutional.\textsuperscript{82} Finally, the state has the burden of proving it used the least restrictive means available for attaining its goal.\textsuperscript{83}

\begin{itemize}
\item \textsuperscript{71} Id.
\item \textsuperscript{72} Id. This note focuses on substantive due process, the component changed by the amendment.
\item \textsuperscript{73} United States v. Carolene Prods. Co., 304 U.S. 144, 152 (1938).
\item \textsuperscript{74} See, e.g., Williamson v. Lee Optical, 348 U.S. 483, 491 (1955).
\item \textsuperscript{75} Lulay v. Lulay, 739 N.E.2d 521, 529 (Ill. 2000).
\item \textsuperscript{76} In re Commitment of Dennis H., 647 N.W.2d 851, 855 (Wis. 2002).
\item \textsuperscript{77} Ferris, supra note 67, at 968.
\item \textsuperscript{78} In re Dennis H., 647 N.W.2d at 856.
\item \textsuperscript{79} Strict scrutiny is also used when the law makes a distinction based on a suspect class such as race. CHEMERINSKY, supra note 70, at 542.
\item \textsuperscript{80} Id. at 541.
\item \textsuperscript{81} Lulay, 739 N.E.2d at 529.
\item \textsuperscript{82} CHEMERINSKY, supra note 70, at 542.
\item \textsuperscript{83} Id. at 541; see Shelton v. Tucker, 364 U.S. 479, 488 (1960) ("[E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved.")
\end{itemize}
The Supreme Court has consistently held that an individual's interest in avoiding involuntary commitment is a fundamental right.84 In O'Connor, the Court held that "[t]here can be no doubt that involuntary commitment to a mental hospital, like involuntary commitment of an individual for any reason, is a deprivation of liberty which the state cannot accomplish without due process of law."85 Later, in Addington v. Texas, the Court held that "civil commitment . . . constitutes a significant deprivation of liberty that requires due process protection."86 In Vitak v. Jones, the Court recognized that even transfer from prison to a mental hospital implicates a liberty interest protected by the Due Process Clause of the Fourteenth Amendment because of the stigmatizing consequences.87

Due to the fundamental interest at stake, when courts analyze the constitutionality of the Illinois amendment, which permits involuntary commitment to a mental hospital, strict scrutiny is required. The state must prove by clear and convincing evidence it had an interest sufficient to justify curtailing such a fundamental right.88 This level of review, strict scrutiny, will be used as the standard in the following analysis of whether the Illinois amendment satisfies due process.89

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84. See O'Connor, 422 U.S. at 580 (Burger, C.J., concurring).
85. Id.
[I]t is indisputable that involuntary commitment to a mental hospital . . . can engender adverse social consequences to the individual. Whether we label this phenomena 'stigma' or choose to call it something else is less important than that we recognize that it can occur and that it can have a very significant impact on the individual.

88. Addington, 441 U.S. at 433. "We conclude that the individual's liberty interest . . . is of such weight and gravity, that due process requires the state to justify confinement by proof more substantial than a mere preponderance of the evidence." Id. at 427.

89. The supreme courts in Wisconsin and Washington did not use this level of scrutiny. See discussion infra Analysis of the Amendment: Is the Amendment Void for Vagueness?
IS THE AMENDMENT VOID FOR VAGUENESS?

A primary concern regarding the constitutionality of the Illinois amendment is whether it satisfies that aspect of due process that requires a law to set forth notice of the conduct prohibited or required. The statute furnishes such notice by providing objective standards; these standards also permit uniform application and enforcement of the law. "[A] statute is void for vagueness if it fails to give [such] notice to those wishing to obey the law . . . ." Finally, the "vice of vagueness" is aggravated when the statute in question, such as the Illinois amendment, "inhibits the exercise of individual freedoms affirmatively guaranteed by the Federal Constitution." Statutes that lowered the standard for involuntary commitment survived challenges on void for vagueness grounds in both Wisconsin and Washington. The courts interpreting the statutes reasoned that because the statutes provided adequate notice, objective criteria, and required an evidential showing by clear and convincing evidence, they were not void for vagueness. These rulings provide a means by which to analyze the constitutionality of the Illinois amendment.

One of these states, Wisconsin, added language to allow for commitment before the danger level required by the prior statute was met. This additional language, known as the "fifth standard," survived a constitutional challenge on void for

90. In re Dennis H., 647 N.W.2d at 858.
92. In re Dennis H., 647 N.W.2d at 858.
94. See generally Wis. Stat. § 51.20(1)(a)2.e (1999-2000); Wash. Rev. Code Ann. § 71.05.020 (West 2008) (while the statute has been amended since the 1986 ruling, the substantive portion, on which the court's decision is based, remains the same); In re Dennis H., 647 N.W.2d at 859; In re Det. of LaBelle, 728 P.2d. 138, 143 (Wash. 1986).
95. See In re Dennis H., 647 N.W.2d at 859; In re Det. of LaBelle, 728 P.2d. at 143.
96. Wis. Stat. § 51.20(1)(a)2.e.
vagueness grounds in the case of In re Commitment of Dennis H., which was before the Wisconsin Supreme Court in 2002. The court found the statute provided objectively discernable standards by which commitment decisions could be made, reasoning that because the statute provided five objective criteria, "[i]t precisely, though perhaps clumsily, identify those to whom it apply[d]." The court held that the definition of dangerousness provided was not unconstitutionally vague, reasoning that it was "not so obscure that men of common intelligence must necessarily guess at its meaning and differ as to its applicability."

A similar statute in Washington also survived a challenge on void for vagueness grounds in the case of In re Detention of LaBelle. Although the new, "gravely disabled" standard survived, the Washington Supreme Court identified two specific areas of concern that could arise in its application. The

97. In re Dennis H., 647 N.W.2d at 858. Based on the testimony of two psychiatrists, a jury determined the subject was in need of inpatient treatment and the Milwaukee County Circuit Court ordered him committed for a period of six months. Id. at 854.
98. See id. at 858.
99. Id.

First, the subject of a commitment petition must be mentally ill. Second, the person . . . must be unable, "because of mental illness" to make "an informed choice as to whether to accept or refuse medication or treatment." Third, the person must show a "substantial probability" that he or she "needs care or treatment to prevent further disability or deterioration." Fourth, the person must evidence a "substantial probability that he or she will, if left untreated, lack services necessary for his or her health or safety." Fifth, the person must evidence a "substantial probability that he or she will, if left untreated . . . suffer severe mental, emotional, or physical harm that will result in the loss of the individual's ability to function independently in the community or the loss of cognitive or volitional control over his thoughts or actions."

Id. at 858-59.
100. Id. at 859 (citing In re Commitment of Curriel, 597 N.W.2d 697, 709 (Wis. 1999)).
101. See WASH. REV. CODE ANN. § 71.05.020 (West 2008).
102. In re Det. of LaBelle, 728 P.2d at 144-45.
103. Id. at 144. Four respondents appealed from separate orders involuntarily committing them for treatment of mental disorders following hearings at which trial courts found them gravely disabled. Id. at 141.
first was that under the gravely disabled standard the danger arose from passive behavior,\textsuperscript{104} such as self-neglect or inaction,\textsuperscript{105} as opposed to active behavior,\textsuperscript{106} and as such the danger might be more difficult to identify objectively.\textsuperscript{107} The court also recognized that the nature of the inquiry, which necessarily involved critical judgments concerning a person’s ability to provide for his basic needs,\textsuperscript{108} was such that there was “a danger of imposing majoritarian values on a person’s chosen lifestyle which, although not sufficiently harmful to justify commitment, may be perceived by most of society as eccentric, substandard, or otherwise offensive.”\textsuperscript{109}

Given these two areas of concern, the court held that “the State must present recent, tangible evidence of failure or inability to provide for such essential human needs as food, clothing, shelter, and medical treatment which presents a high probability of serious physical harm within the near future.”\textsuperscript{110} Additionally, recognizing the danger of erroneously committing under the new language, the court held that in order to justify such a massive curtailment of liberty, the “care must be shown to be essential to the individual’s health or safety.”\textsuperscript{111} So construed, the court held that the language was not unconstitutionally vague.\textsuperscript{112}

As compared to the statues in Wisconsin and Washington,\textsuperscript{104} \textsuperscript{105} \textsuperscript{106} \textsuperscript{107} \textsuperscript{108} \textsuperscript{109} \textsuperscript{110} \textsuperscript{111} \textsuperscript{112}

\begin{itemize}
  \item May the State fence in the harmless mentally ill solely to save its citizens from exposure to those whose ways are different? One might as well ask if the State, to avoid public unease, could incarcerate all who are physically unattractive or socially eccentric. Mere public intolerance or animosity cannot constitutionally justify the deprivation of a person’s physical liberty.
  
  \textit{O’Connor}, 422 U.S. at 576.
  \item \textit{In re Det. of LaBelle}, 728 P.2d at 144.
  \item \textit{Id. at 146} (emphasis in original).
  \item \textit{Id. at 144-45}.
\end{itemize}
in Illinois, the conduct regulated, "mental and emotional deterioration," is not defined in the amendment and has not yet been interpreted by case law.\(^{113}\) Additionally, under a plain meaning analysis, it does not provide criteria that could be used as a basis for objective application.\(^{114}\) In legislative hearings, Representative Louis Lang described emotional deterioration as "a subjective term with no definition whatsoever in the Bill."\(^{115}\) He commented further that:

The due process that is presumed in this particular legislation is constitutionally vague. [I]n the effort of making sure . . . that everyone gets the treatment they need we must not resort to unconstitutionally vague language in a Bill that provides for involuntary commitment of our citizens. It's a very serious legal principle and we must not ever cross that line.\(^{116}\)

A great deal will depend on the level of scrutiny the courts in Illinois use when they determine if the language "mental and emotional deterioration" is void for vagueness. When interpreting the new standards, the courts in Wisconsin and Washington both used a rational basis level of review.\(^{117}\) In Wisconsin, the court did so because it recognized that it was dealing with "issues of unusual delicacy, in an area where professional judgments regarding desirable procedures are constantly and rapidly changing."\(^{118}\) As such, the court reasoned that "[e]very presumption must be indulged to sustain the law if at all possible, and wherever doubt exists as to a legislative enactment's constitutionality, it must be resolved in favor of

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114. Debate, supra note 57, at 204.
115. Id.
116. Id. at 205. Representative Lang further stated that the language was "far too vague from either a practical point of view to determine who ought to be committed or definitely from a legal and constitutional point of view." Id. See Santosky v. Kramer, 455 U.S. 745, 762 (1982) (noting that proceedings that "employ imprecise substantive standards that leave determinations unusually open to subjective values" magnify the risk for erroneous deprivations of private interests).
117. See In re Dennis H., 647 N.W.2d at 855; In re Det. of LaBelle, 728 P.2d at 145.
118. Id.
constitutionality."119

In its determination of the standard of review to apply, the Washington Supreme Court stated that:

As petitioners point out, where as here a significant deprivation of liberty is involved, statutes must be construed strictly. . . . On the other hand, our primary objective in interpreting a statute is to ascertain and give effect to the intent of the Legislature. . . . In so doing, the spirit and intent of the law should prevail over the letter of the law.120

The intent of the legislature, as the court recognized later in the opinion, was "to broaden the scope of the involuntary commitment standards in order to reach those persons in need of treatment . . . who did not fit within the existing, restrictive, statutory criteria."121 In giving deference to the legislative intent, the Washington Supreme Court also analyzed the statute under a lower level of review.122

If courts in Illinois use a rational basis level of review, as they did in Wisconsin and Washington, the phrase "mental and emotional deterioration," though undefined, may bear a sufficiently rational basis to the state interest in preventing self-danger to satisfy due process.123 However, if the courts follow the Supreme Court precedent that classifies the liberty interest as fundamental, and consequently use strict scrutiny to interpret the statute, they will likely conclude that the amendment does not provide sufficient notice of the behavior regulated to permit objective application, and as such find it void for vagueness.124

119. Id. at 856 (citing State v. Carpenter, 541 N.W.2d 105, 263 (Wis. 1995)).
120. In re Det. of LaBelle, 728 P.2d at 145.
121. Id.
122. See id.
123. The statute does define "dangerous conduct" which could be used to provide objective criteria, however, dangerous conduct is the second part of a two-part requirement, and the first part, emotional or mental deterioration, remains undefined. Act of June 1, 2008, Pub. Act 95-602, 2007 Ill. Laws 7839-40.
124. A final means by which to analyze whether the language is void for vagueness is to compare it to the language used in Preventive Outpatient Treatment (PVOT) statutes, which have also been challenged on void for vagueness grounds. Scherer, supra note 4, at 387. It can be argued that because involuntary commitment statutes are more restrictive of an individual's liberty interest than PVOT statutes,
Not only is there an issue of vagueness because the behavior the amendment seeks to regulate is undefined and insusceptible of objective application, but the legislature has made the standard of commitment even less clear by including the words “unable to understand his need or her need for treatment.” In Illinois, there is a presumption that the mentally ill are competent. This presumption applies even to those who have been involuntarily committed, and treatment, such as the administration of psychotropic medication, can only be made upon application to a court that the recipient lacks the capacity to make a reasoned decision. So, by allowing forcible commitment of only those people who are unable to make treatment decisions, which describes only those who are functioning at a very low level, the legislature may inadvertently have done the opposite of what it intended to do. It may in fact have excluded all but the most critically ill, including those who could have been committed prior to the amendment. Although the legislative intent was to lower the standard for the involuntary commitment of the mentally ill, it could be argued that the amendment actually raised the standard instead.

they should provide notice of the behavior regulated that is at least as clear, if not more clear.

126. Id.
127. Jennifer Gutterman, Waging a War on Drugs: Administering a Lethal Dose to Kendra's Law, 68 FORDHAM L. REV 2401, 2429 (2000). “[T]he Supreme Court in Mills v. Rogers found a distinction between the standards governing involuntary commitment and those applying to incompetency. Thus it is now acknowledged that many mentally ill individuals retain the capacity to function in a competent manner and control their treatment regimens.” Id. at 2429 (citing Mills v. Rogers, 457 U.S. 291, 303 (1982)).
129. In re C.E., 641 N.E.2d 345, 347 (Ill. 1994). The mental health code “permits the trial court to authorize the involuntary administration of psychotropic medication to a person . . . when the court finds by clear and convincing proof, following a full hearing, that the recipient . . . is incapable of making the drug-treatment decision on his own behalf.” Id.
130. In re Phyllis P., 695 N.E.2d 851, 852 (Ill. 1998). “As the Mental Health Code explicitly provides, ‘[n]o recipient of services shall be presumed legally disabled.’” Id. (citing 405 ILL. COMP. STAT. 5/2-101 (2006)).
Finally, including the language "unable to understand his or her need for treatment" in a standard for involuntarily commitment raises some serious ethical issues. One is that the standard requires a third party to make a number of value judgments: that a person is ill, that appropriate treatment is available, that he would benefit from the treatment, and that he should be forcibly committed to ensure he receives it. "Unable to understand a need for treatment" could appropriately describe someone who does not agree with a diagnosis or who prefers to make his own treatment decisions. Additionally, the statutory language is based on current medical theories about mental illness. And finally, without implying it was the legislature's intent, the fact remains that the standard opens the door for abuse by the government. As the Illinois Supreme Court noted, "in the past, other governments have used involuntary psychiatric treatment as a 'ruse' and a 'device' to silence critics." Because of the gravity of these issues, it would be unwise to include the language "unable to understand a need for treatment," within a standard for involuntary commitment.

**Level of Danger Required**

A second concern regarding the constitutionality of the Illinois amendment is whether the danger the state seeks to prevent is sufficient to justify the deprivation of the liberty interest involved. In *O'Connor v. Donaldson*, the United States

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133. See id.
134. SAKS, supra note 8, at 96-97. "The typical reasons patients refuse medication generally do not reflect incompetence and are worthy of respect."
135. See discussion infra pp. 209-11.
136. See *In re C.E.*, 641 N.E.2d at 352.
137. Id. (citing People v. Valentine, 558 N.E.2d 807, 809 (Ill. 1990)); see also SAKS, supra note 8, at 193-94. "Allowing denial to be a basis for an incompetency finding—and thus forced treatment—is in fact fraught with danger. . . . [I]t would also allow us to characterize political dissidents as ill, and then to use their understandable denial that they are ill as a basis for their involuntary treatment. . . ." Id.
138. See *O'Connor*, 422 U.S. at 575.
Supreme Court established a two-part standard for involuntary commitment: a medical standard, that the person be mentally ill, and a legal standard, that the person be dangerous. However, the Court did not establish the level of danger required to justify commitment. State legislatures have attempted to fill this gap in their civil commitment statutes. While the levels of danger that must be shown vary from state to state, legislators generally consider three factors: the nature of the harm they seek to prevent, the immediacy of the danger, and the likelihood of the danger occurring. As applied, the greatest harm is that which is severe, imminent, and certain.

When deciding if the level of danger required by the Wisconsin statute satisfied due process, the circuit court in In re Dennis H. concluded the new standard constituted a new description of dangerousness sufficient to justify commitment; it encompassed a requirement of present dangerousness, "albeit 'in a little different vocabulary.'" The court found the statute constitutionally appropriate because it "did not dispense with [the requirement of] dangerousness as a pre-condition of commitment;" it "merely defined it in a different way." In affirming the circuit court's decision, the Wisconsin Supreme Court reasoned that:

By permitting intervention before a mentally ill person's condition becomes critical, the legislature has enabled the mental health treatment community to break the cycle associated with incapacity to choose medication or treatment, restore the person to a relatively even keel, prevent serious and potentially

139. See id.
140. Ferris, supra note 67, at 961.
141. Id. at 973.
142. Id. at 966.
143. Id.
144. Id.
145. In re Dennis H., 647 N.W.2d at 855.
146. Id. at 856.
147. Id.
148. Id.
149. Id. at 855.
catastrophic harm, and ultimately reduce the amount of
time spent in an institutional setting. This type of
"prophylactic intervention" does not violate substantive
due process.\textsuperscript{150}

Because the Wisconsin statute permits commitment in order
to prevent danger, logically it cannot require dangerousness as a
prerequisite to commitment. In order to continue to pass
constitutional muster, the Wisconsin Supreme Court expressly
changed the definition of dangerousness;\textsuperscript{151} it redefined danger
from narrow to broad based on an increased awareness of the
pathology of mental illness.\textsuperscript{152} Additionally, the court
recognized a more "flexible interpretation of dangerous,"\textsuperscript{153} no
longer requiring that a mentally ill person be "literally"
dangerous.\textsuperscript{154} Rather than using \textit{O'Connor} to strike down the
Wisconsin statute, the Wisconsin court "used \textit{O'Connor} to justify
its ruling while presenting the \textit{parens patriae} power in the
clothing of dangerousness."\textsuperscript{155} The problem with this reasoning
is that the legal standard set by the United States Supreme Court
requires a showing of dangerous conduct before the state can
commit a mentally ill person against his will.\textsuperscript{156} If a state's intent
is to commit an individual based on behavior that is not
sufficiently dangerous to satisfy due process, it cannot describe
the behavior on which it wants to commit and then label the
behavior "dangerous."\textsuperscript{157}

When interpreting a statute similar to Wisconsin's fifth

\begin{itemize}
\item \textsuperscript{150} \textit{Id. at 863} (emphasis added).
\item \textsuperscript{151} Erickson et al., \textit{supra} note 4, at 363; see Geller et al., \textit{supra} note 31, at 135
(\"[T]he court's definition of what is dangerous was what most would call 'need for
treatment.'\")
\item \textsuperscript{152} Erickson et al., \textit{supra} note 4, at 363.
\item \textsuperscript{153} Geller et al., \textit{supra} note 31, at 130.
\item \textsuperscript{154} Erickson et al., \textit{supra} note 4, at 377.
\item \textsuperscript{155} Geller et al., \textit{supra} note 31, at 136.
\item \textsuperscript{156} See \textit{O'Connor}, 422 U.S. at 575.
\item \textsuperscript{157} It is an established principle in law that "the mere entitling of a procedure
cannot change its nature or character." State v. Froelich, 146 N.E. 733, 737 (1925); see
generally \textit{GEORGE ORWELL}, \textit{1984} (1949) (discussing "NewSpeak" and the impact on
society of a government that changes the meaning of words in order to
accommodate its political agenda).
\end{itemize}
standard, the Washington Supreme Court, in the case of *In re Detention of LaBelle*, found that the statute reached the level of danger required by *O'Connor*. Although the appellants contended it did not reach the requisite level because it did not require a showing of imminent danger, the court did not agree, reasoning that by the time the state files a petition for involuntary commitment, the individual will already have been detained in a hospital for a period of time. The care received will have lessened the imminence of the danger. As a result, "[t]he State's continued interest in confining and treating such individuals would be frustrated by a requirement of 'imminent danger.'" Rather than focusing on immediacy as the determinative factor, the court looked at the type of harm and the likelihood of it occurring. The court required, "a showing of a substantial risk of danger or serious physical harm resulting from failure to provide for essential health and safety needs." Given the two factors were satisfied, the court concluded that the danger requirement had been met.

When analyzed according to the factors as defined by statute in Wisconsin and Washington, the danger required by Illinois is lower. With respect to type of harm, Illinois only requires that the harm be "serious," while Wisconsin requires it to be "severe," and Washington requires it to be "essential." In addition, Illinois has no immediacy

158. *In re Det. of LaBelle*, 728 P.2d at 146.
159. *Id.* at 143-44.
160. *Id.*
161. *Id.*
162. *Id.* at 146.
163. *Id.* at 144. "A requirement of imminent danger as a prerequisite to continued confinement could result in release of mentally ill patients who are still unable to provide essential health and safety needs."
164. *Id.*
165. *Id.*
requirement, having removed a former requirement of "in the near future" and not replaced it. Finally, in Illinois, the likelihood of harm occurring is significantly lower: "reasonably expected to suffer or continue to suffer mental deterioration or emotional deterioration, or both, to the point that the person is reasonably expected to engage in dangerous conduct," which is lower than Wisconsin's "substantially probable" or Washington's "substantial risk."

As it did with the issue of vagueness, the level of scrutiny the courts use will determine whether the level of danger described in the Illinois amendment meets the constitutional standard. Under a rational basis level of review, it is possible that the state's interest in avoiding "dangerous conduct," as defined in the statute, is sufficiently related to the means used to satisfy due process. Under strict scrutiny, however, the danger described by the Illinois amendment is not serious enough to justify the deprivation of a liberty interest of the magnitude of avoiding involuntary confinement. To justify the deprivation, the danger the state is attempting to prevent must be critical.

This conclusion is supported by the holding in O'Connor, in which the Supreme Court held that the mentally ill person is not dangerous if he is "capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." The statute in Wisconsin accords with Supreme Court precedent because it provides that if care is available in the community, the substantial probability of harm

171. Id.
173. WASH. REV. CODE ANN. § 71.05.020 (West 2008).
174. See Lulay, 739 N.E.2d at 529.
175. See id.
176. Id.
177. Id.
In Illinois, however, dangerous conduct is defined as a person's inability to provide for basic needs without the assistance of family or outside help. In other words, if the individual needs help, he can be committed, even if with that help he would have survived. This is arguably in violation of Supreme Court precedent and, as such, is violative of due process rights.

In fact, the legislature's description of "dangerous conduct" in the Mental Health Code is strikingly similar to its definition of "self-neglect" in the Elder Abuse and Neglect Act. "Self-neglect" in the Elder Abuse and Neglect Act is defined as:

[A] condition that is the result of an eligible adult's inability, due to physical or mental impairments, or both, or a diminished capacity, to perform essential self-care tasks that substantially threaten his or her own health, including: providing essential food, clothing, shelter, and health care; and obtaining goods and services necessary to maintain physical health, mental health, emotional well-being, and general safety.

When the two statutes are analyzed according to the three factors used to define danger, "self-neglect" is a significantly more dangerous behavior than "dangerous conduct." Even though the type of harm is similar, under the Mental Health Code, a person can be committed if he is reasonably expected to suffer mental or emotional deterioration to the point that he is reasonably expected to engage in dangerous conduct at some point.

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179. In re Dennis H., 647 N.W.2d at 859. Although the language in the Washington statute does not address the issue, the Washington Supreme Court did quote the relevant language from O'Connor in its opinion in In re Det. of LaBelle, 728 P.2d at 143.


181. See id.

182. O'Connor, 422 U.S. at 576.

183. 320 ILL. COMP. STAT. 20/2 (i-5) (2006); see Debate, supra note 57, at 208 ("[T]hat Bill produced a knock at the door by someone who was going to offer services. This Bill, in contrast with a very similar kind of standard, can lead to involuntary commitment.")

184. 320 ILL. COMP. STAT. 20/2 (i-5) (2006).

unspecified time in the future.\textsuperscript{186} In contrast, self-neglect has no immediacy or likelihood requirement because \textit{the harm must be actually occurring}.\textsuperscript{187}

By defining the same behavior as "dangerous" when applied to the mentally ill and as "self-neglect" when applied to the elderly, Illinois has created two problems.\textsuperscript{188} First, it has done the same thing Wisconsin did: described behavior on which it intends to commit the mentally ill and then labeled the behavior dangerous.\textsuperscript{189} If the behavior the legislature defined as "dangerous" is not truly dangerous, then the behavior does not meet the legal standard required by the Supreme Court, and the amendment does not satisfy due process.\textsuperscript{190} More significantly, the legislature seems not to have considered the elderly mentally ill, whose behavior may fall under either the statutory definition of "dangerous conduct" or "self-neglect."\textsuperscript{191} If the behavior is classified as dangerous conduct, the elderly mentally ill person can be involuntarily committed.\textsuperscript{192} If it is classified as self-neglect, an agency designated by the Department on Aging of the State of Illinois will develop a service care plan, which provides needed services and which "involves the least restriction of the eligible adults' activities."\textsuperscript{193} For Illinois to legislate that the same behavior has different consequences depending on the code section used permits subjective application of the law in violation of due process.

\textit{ARE BOTH MEDICAL AND LEGAL STANDARDS REQUIRED?}

A third concern regarding the constitutionality of the Illinois amendment is whether it permits involuntary

\begin{flushleft}
\textsuperscript{187} 320 ILL. COMP. STAT. 20/2 (i-5) (2006).
\textsuperscript{189} See In re Dennis H., 647 N.W.2d at 380.
\textsuperscript{190} See O'Connor, 422 U.S. at 576.
\textsuperscript{193} 2006 Ill. Legis Serv. P.A. 94-1064 (H.B. 4976); 320 ILL. COMP. STAT. 20/5 (a).
\end{flushleft}
commitment on a finding of mental illness alone. It is well established in the law that a showing of both mental illness and dangerous conduct is required to satisfy substantive due process before involuntary commitment. A finding of mental illness alone cannot justify commitment. As such, when enacting statues allowing involuntary commitment of the mentally ill, legislatures need to craft laws that do not commit those who are not a danger to themselves.

When analyzing the "gravely disabled" standard, the Washington Supreme Court noted that the possibility existed that persons could be committed solely because they were suffering from a mental illness. The court cautioned that "[i]nvoluntary commitment on this basis alone is not supported by a sufficiently compelling state interest to justify such a significant deprivation of liberty." While Washington's statute passed muster, the court cautioned that because the statute "incorporate[d] medical technology, a decision to commit under this standard may involve more a medical decision than a legal one. Consequently, there is a danger that excessive judicial deference will be given to the opinions of mental health professionals, thereby effectively insulating their commitment recommendations from judicial review." Because of this possibility, the court held it was particularly important to require evidence to provide a "factual basis for concluding that an individual 'manifests severe [mental] deterioration.'

194. See O'Connor, 422 U.S at 575.
195. Id.
196. Id.
197. People v. Lang, 498 N.E.2d.1105, 1126 (Ill. 1986).
198. In re Det. of LaBelle, 728 P.2d at 146.
199. Id.
200. Id.
201. Id.; see generally Nan D. Hunter, Justice Blackmun, Abortion, and the Myth of Medical Independence, 72 BROOK. L. REV 147 (2006) (discussing Roe v. Wade and the interplay between law and medicine). "The Court in essence delegated juridical authority to physicians. Regulation was replaced by diagnosis, which was itself regulation." Id. at 194. "Roe's invalidation of all extant abortion laws delegated responsibility to another center of power." Id. at 196 (citing Roe v. Wade, 410 U.S. 113, 163 (1973)).
justify commitment, care must be shown to be *essential* to an individual's health or safety." The court held that it was not sufficient that the care required was "preferred, beneficial, or even [in the patient's] best interests." Because the Washington statute met these standards, the court found it was constitutionally based on a showing of both danger and mental illness and not mental illness alone.

The Wisconsin Supreme Court analyzed the same issue in *In re Dennis H.*, in which the plaintiff argued that the fifth standard's definition of dangerousness was "essentially no more than a reiteration of the definition of mental illness . . . and therefore allow[ed] involuntary commitment upon a finding of mental illness alone." The court found, however, that the fifth standard still required dangerousness:

The fifth standard's focus is on dangerous to self—dangerousness of a particularly insidious nature because it is chronic and cyclical (measured by treatment history and recent acts or omissions), and brought on by mental illness that produces an incapacity to make medication or treatment decisions.

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202. *In re Det. of LaBelle*, 728 P.2d at 146.
203. *Id.* This is consistent with the Supreme Court's reasoning in *O'Connor* that the State may not confine for the purpose of "raising the living standards of those capable of surviving safely in freedom." *O'Connor*, 422 U.S. at 576.
204. *In re Det. of LaBelle*, 728 P.2d at 146.
205. *Id.*
206. *In re Dennis H.*, 647 N.W.2d at 858.
207. *Id.* In a concurring opinion, Chief Justice Shirley S. Abrahamson articulated concern regarding the constitutionality of the new standard:

Both mental illness and dangerousness are necessary to satisfy the requirements of substantive due process for involuntary civil commitment. A court must balance the desires of mental health professionals, friends, and family members who believe that care and treatment is in the best interests of a person who is mentally ill, and the constitutional liberty interests of individuals to be free from unwanted and unnecessary restraints. . . . This balance has been struck by requiring proof of mental illness and imminent dangerousness to self . . . before permitting involuntary civil commitment. The fifth standard comes perilously close to upsetting this balance. It passes constitutional muster . . . only so long as courts require significant evidence of the statutory elements and treatment is in fact provided.

*Id.* at 864-65 (Abrahamson, C.J., concurring).
as well as a substantial probability of incapacity to care for oneself. The fifth standard does not apply to mentally ill people who are not dangerous to themselves.\textsuperscript{208}

While the court found the statute met the requirement of distinguishing between those mentally ill who are dangerous and those who are not,\textsuperscript{209} it essentially held that the incapacity to make treatment decisions amounts to dangerousness.\textsuperscript{210} The court does not require factual evidence of dangerous conduct caused by the incapacity,\textsuperscript{211} or even evidence of deterioration caused by the incapacity which might lead to dangerous conduct,\textsuperscript{212} but is satisfied by a showing of the incapacity itself.\textsuperscript{213} In so holding, the court relies on an assumption held by some in the mental health field: that the incapacity to make treatment decisions is inherently dangerous.\textsuperscript{214} If the assumption is correct, then the court's reasoning is valid.\textsuperscript{215} If the assumption is not correct, however, and such incapacity is not inherently dangerous, but rather the symptom or manifestation of a disease, then the court has permitted commitment on the basis of mental illness alone.\textsuperscript{216} Under this analysis, "the dangerousness requirement is eviscerated and mental illness becomes the sole criteria for civil commitment."\textsuperscript{217}

As applied to the amendment in Illinois, the reasoning the courts use will determine if the legislature distinguished between those mentally ill who are dangerous and those who

\begin{itemize}
\item \textsuperscript{208} Id. at 860.
\item \textsuperscript{209} Id. at 862.
\item \textsuperscript{210} The court supports this conclusion by stating that mentally ill persons who lack the capacity to make informed decisions are "clearly dangerous because their incapacity to make treatment decisions makes them more vulnerable to severely harmful deterioration." Id.
\item \textsuperscript{211} See id.
\item \textsuperscript{212} Id.
\item \textsuperscript{213} Id.
\item \textsuperscript{214} Erickson et al., supra note 4, at 381.
\item \textsuperscript{215} See In re Dennis H., 647 N.W.2d at 862.
\item \textsuperscript{216} See id.
\item \textsuperscript{217} Ferris, supra note 67, at 974.
\end{itemize}
If they follow the reasoning used by the court in Washington, which was to require evidence to provide for a factual basis, it is possible the Illinois statute is constitutional under a rational basis level of review, even though the level of care required in Illinois is lower. However, courts in Illinois may follow the Wisconsin court's reasoning, that given the nature of this particular disease, in which a symptom of the disease, the inability to understand treatment decisions, is inherently dangerous. In that case, then the question then becomes whether the assumption the Wisconsin court based its decision on is sound. This is a crucial determination, because if the inability to make treatment decisions is a symptom of a disease and not inherently dangerous conduct, then even under the lower standard of review the amendment is unconstitutional.

ARGUMENTS IN SUPPORT OF THE AMENDMENT

Two main arguments support the constitutionality of the Illinois amendment. Both arguments are based on current medical understanding of mental illness. The first is that mental illness produces incapacity to make treatment decisions. The second is based on the first: because of the nature of mental illness, the danger requirement has been satisfied by a showing of mental illness alone.

Supporters of these arguments feel this basis is justified because of the tremendous advances in the understanding of mental disorders that science has made over the past twenty

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218. See In re Dennis H., 647 N.W.2d at 862; In re Det. of LaBelle, 728 P.2d at 146.
219. In re Det. of LaBelle, 728 P.2d at 146.
221. In re Dennis H., 647 N.W.2d at 862.
222. Erickson et al., supra note 4, at 381.
223. See In re Dennis H., 647 N.W.2d at 861, 863.
224. Erickson et al., supra note 4, at 381.
225. In re Dennis H., 647 N.W.2d at 861.
226. Id. at 863.
years.\textsuperscript{227} As a result of these advances, researchers now have a better understanding of how mental illnesses affect brain morphology and functioning.\textsuperscript{228} In particular, there has been an increased awareness that many people with severe mental illness do not believe they are sick.\textsuperscript{229} This condition, termed anosognosia,\textsuperscript{230} prevents the mentally ill effected from voluntarily seeking treatment.\textsuperscript{231} Research has also shown that this lack of insight is often correlated with decreased cognitive abilities.\textsuperscript{232} Consequently, it is argued that many mentally ill persons have such impaired insight into their illnesses\textsuperscript{233} that they have lost the ability to make rational choices.\textsuperscript{234} Current research has shown that these behaviors are not really choices, but rather symptoms of a disease.\textsuperscript{235} As such, legislatures, such as Illinois', have recognized that "a benevolent and lucid mental health policy should have as its underpinnings an understanding of the pathogenesis of mental illness and should conform its principles to enhancing individual liberties by providing treatment, even over a person's objections, when there is compelling evidence that such treatment will uphold these goals."\textsuperscript{236}

**RESPONSE TO ARGUMENTS IN SUPPORT**

Although it could be argued that given the unique nature of the disease, a diagnosis of mental illness is sufficient to satisfy both the medical and legal standards for involuntary commitment,

\begin{itemize}
\item \textsuperscript{227} Scherer, supra note 4, at 382.
\item \textsuperscript{228} Erickson et al., supra note 4, at 381.
\item \textsuperscript{229} Id.
\item \textsuperscript{230} Id.
\item \textsuperscript{231} Id.
\item \textsuperscript{232} Id.
\item \textsuperscript{233} Id. at 385.
\item \textsuperscript{234} Id.
\item \textsuperscript{235} Id.
\item \textsuperscript{236} Id.; see Geller et al., supra note 31, at 138 ("Perhaps it is time to recognize that the abrogation of the opportunity for treatment is a much greater impediment to autonomy and self determination than is the denial of treatment in the name of sustaining the faux liberty of a psychotic state.")
\end{itemize}
there are two serious problems with this reasoning. The first is that current medical understanding is a theory, not a legal principle, and as such cannot be used to satisfy a legal standard on its own.\textsuperscript{237} In \textit{O'Connor}, the Supreme Court recognized the uncertainty of diagnosis in the field of psychiatry and the tentativeness of professional judgment.\textsuperscript{238} The Court pronounced that "few things would be more fraught with peril than to irrevocably condition a State's power to protect the mentally ill upon the providing of 'such treatment as will give [them] a realistic opportunity to be cured.'"\textsuperscript{239} Although the Wisconsin Supreme Court recognized the uncertainty endemic to psychiatry as expressed in \textit{O'Connor},\textsuperscript{240} it used it as a justification for deferring to the legislature.\textsuperscript{241} In so ruling, the court placed too much emphasis on the uncertainty of psychiatry and insufficient emphasis on the legal principal involved: the state's power to confine its citizens.\textsuperscript{242}

One aspect underlying this uncertainty is that psychiatry, like all areas of medicine, continues to change.\textsuperscript{243} As the Illinois Supreme Court recognized:

Diagnostic classifications in the mental-health field are constantly undergoing revision, and thus it would be unwise to equate the legal term "mentally ill" in section 1-119 with the laundry list of diagnoses or psychiatric classifications in vogue at a given moment. Otherwise, the definition of "mental illness" could ebb and flow depending on the then-current consensus of mental-health professionals.\textsuperscript{244}

Consider that lobotomies were the conventional treatment for mental illness in the 1940s and 1950s—\textsuperscript{245} in fact, the physician

\textsuperscript{237} See \textit{O'Connor}, 422 U.S. at 584.
\textsuperscript{238} \textit{Id}.
\textsuperscript{239} \textit{Id} at 588-89.
\textsuperscript{240} In re \textit{Dennis H}., 647 N.W.2d at 856.
\textsuperscript{241} \textit{Id}.
\textsuperscript{242} See \textit{id}.
\textsuperscript{243} \textit{People v. Lang}, 498 N.E.2d at 1125.
\textsuperscript{244} \textit{Id}.
\textsuperscript{245} Sarah Linsley Starks & Joel T. Braslow, \textit{The Making of Contemporary American Psychiatry Part I: Patients, Treatments, and Therapeutic Rationales Before and After World
who perfected the procedure won the Nobel Prize in 1949. Additionally, homosexuality was classified as a mental illness in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders until the 1974 edition. We cannot conceive of the state committing a homosexual today because he does not recognize his need for treatment.

An additional reason for this uncertainty is that even within the same time period experts in the field of mental illness disagree. The Court in Ake v. Oklahoma held “psychiatry is not . . . an exact science, and psychiatrists disagree widely and frequently on what constitutes mental illness, on the appropriate diagnosis to be attached to given behavior and symptoms, on cure and treatment, and on likelihood of future dangerousness.” While some professionals today believe forced treatment has therapeutic value, the American Psychology Association files amicus briefs supporting the right of competent psychiatric patients to refuse treatment. If the premise of the American Psychological Association is correct, forced treatment would be counterproductive to recovery.

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War II, 8 HISTORY OF PSYCHOLOGY 176, 184 (2005).

246. Id. “Although virtually abandoned over 40 years ago, the lobotomy was considered the most ‘scientific of psychiatric interventions’ at the time and Egas Moniz, who directed the first modern lobotomy, was awarded the Nobel Prize in Physiology and Medicine in 1949.” Id. at 184.

247. WILLIAM N. ESKRIDGE, JR., DYNAMIC STATUTORY INTERPRETATION 347 n.20 (1994). “[T]he view of homosexuality as a disease was still widely held in the medical community throughout the 1960s.” Id. at 53.

248. Scherer, supra note 4, at 364 n.11. “Permitting civil commitment on a strict medical model alone could erode rights of individuals due to medical error or inaccurate scientific theories.” Id.; see CHEMERINSKY, supra note 70, at 813-14 (discussing the eugenic sterilization of Carrie Buck, whom the Court described as “feeble minded,” but who was later discovered to be of normal intelligence (citing Buck v. Bell, 274 U.S. 200, 205 (1927))).


250. Id.

251. SAKS, supra note 8, at 18; see BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT 333-37 (American Psychological Association 1997) ("[T]he potential for successful treatment in many contexts would appear to increase when individuals choose treatment voluntarily rather than through coercion . . . Indeed, such coercion may backfire, producing a negative ‘psychological reactance’ that sets up oppositional behavior leading to failure.")

252. See WINICK, supra note 251, at 337.
The second problem with the reasoning used by supporters of the amendment is that courts may not evaluate the merits of a legislature's policy choices; they are limited to considering whether the statute violates a constitutional provision. As the Supreme Court made clear in O'Connor, "[i]n light of the wide divergence of medical opinion regarding diagnosis of and proper therapy for mental abnormalities, 'courts . . . must instead concern themselves with the validity under the Constitution of the methods which the legislature has selected.'" Although the Wisconsin Supreme Court noted that "courts generally proceed with restraint in this complex, delicate, policy-sensitive area, deferring to the procedural scheme the legislature has chosen," the issue is not whether there are different courses of action the legislature could take based on conflicting theories and policies regarding mental illness. The issue is whether, given the liberty interest involved, the method the legislature has chosen satisfies due process.

The question, then, is whether courts in Illinois will permit the legislature's method of using a current medical understanding to satisfy a legal standard or whether they will follow Supreme Court precedent requiring both a medical and legal standard and declare the amendment unconstitutional. The language of the Illinois amendment tracks virtually word for word with current medical understanding: "a person with mental illness who, because of the nature of his or her illness, is unable to understand his need for treatment." Additionally, representatives indicated that their intent was to allow families to get help for their mentally ill relatives who, because of their disease, did not understand their need for treatment.

253. See Kan. Lottery, 186 P.3d at 188.
254. Id.
255. O'Connor, 422 U.S. at 587. "Judges are not free to read their private notions of public policy or public health into the Constitution." Id. at 586.
256. In re Dennis H., 647 N.W.2d at 856.
257. See O'Connor 422 U.S. at 575; In re Dennis H., 647 N.W.2d at 851.
259. Debate, supra note 57, at 209. Representative Kathleen Ryg stated that it
However, Supreme Court precedent does not permit the legislature to set a legal standard on something as uncertain as a psychiatric theory and does not permit courts to evaluate policy choices made by legislatures. The reasoning the Supreme Court used in *District of Columbia v. Heller* applies to the amendment at hand: "'[t]he Constitution leaves the District of Columbia a variety of tools for combating [the problem of mental illness], . . . but . . . constitutional rights necessarily take certain policy choices off the table.'"

**WAYS TO MODIFY THE AMENDMENT**

Given Supreme Court precedent and due process requirements, at a minimum, the legislature should remove the language defining as dangerous a person who could survive with help from the community. But it could be argued that there is no way to bring the amendment in line with the Constitution, because of what the state is attempting to do, *i.e.*, commit an individual based on his status before there is a factual showing of dangerous conduct, is an inherent violation of due process.

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was the legislature's responsibility to look out for mentally ill individuals who "by of the nature of their illnesses, [were] not able to look out for their best interests." *Id.*


263. *Robinson v. California*, 370 U.S. 660, 666 (1962). In *Robinson v. California*, the Supreme Court struck down a statute which made the "status" of narcotic addiction a criminal offense. *Id.* at 666. Even though, as an addict, the defendant was likely to use drugs, which is a crime, he could not be convicted based on his status as an addict before he actually committed a crime. The Court reasoned that a state law that imprisoned a person as a criminal even though "he has never touched a drug or been guilty of irregular behavior inflicts a cruel and unusual punishment." *Id.* at 667. It recognized that "even one day in prison would be a cruel and unusual punishment for the 'crime' of having a common cold." *Id.* As such, it could be argued that a person cannot be committed for having a mental illness. Even though, as a person with a mental illness, he is likely to manifest symptoms of his disease, he cannot be confined based on his status as a person with an illness before he actually becomes dangerous.
The amendment would possibly survive a constitutional challenge under a rational basis level of review.\textsuperscript{264} Under such a low level of scrutiny, the state's interest in preventing "dangerous conduct" as defined in the amendment could possibly justify the deprivation of liberty involved,\textsuperscript{265} and if the court relies on current medical understanding, a showing of mental illness would likely meet both the medical and legal standards required for commitment.\textsuperscript{266} Additionally, under a rational basis level of review the state only needs to show that the means are a reasonable, not a necessary, way to accomplish the objective.\textsuperscript{267}

However, given the liberty interest at stake, the correct standard of review is strict scrutiny, and under strict scrutiny the state must prove by clear and convincing evidence that its interest in regulating the behavior justifies the deprivation of the liberty interest involved.\textsuperscript{268} Under strict scrutiny the state must have a compelling interest in controlling the conduct: the danger must be serious, imminent, and certain.\textsuperscript{269} Additionally, while a showing of mental illness satisfies the medical standard,\textsuperscript{270} the legal standard must still be satisfied by factual evidence of dangerous conduct.\textsuperscript{271} Finally, strict scrutiny requires proof that the law is the least restrictive alternative means for accomplishing the state's goals.\textsuperscript{272} Short of taking a person's life, involuntary confinement is the most restrictive means available to the state for any purpose; certainly there are less restrictive means for controlling "mental or emotional deterioration."\textsuperscript{273}

\textsuperscript{264} See Lulay, 739 N.E.2d at 529.
\textsuperscript{265} Id.
\textsuperscript{266} Erickson et al., \textit{supra} note 4, at 381.
\textsuperscript{267} \textit{Lulay}, 739 N.E.2d at 470; \textit{United States v. Carolene Prods. Co.}, 304 U.S. at 152 n.4.
\textsuperscript{268} See \textit{Lulay}, 739 N.E.2d at 529.
\textsuperscript{269} Id.
\textsuperscript{270} Erickson et al., \textit{supra} note 4, at 364.
\textsuperscript{271} \textit{O'Connor}, 422 U.S. at 563.
\textsuperscript{272} \textit{Lulay}, 739 N.E.2d at 470.
In the final analysis, even if it were possible to bring the amendment in line with the Constitution, it still would not address the real reason the mental health system is failing in Illinois: a lack of funding. A major assumption made with respect to involuntary commitment is that the mentally ill reject treatment, when, in fact, they cannot afford it. For the majority of the severely mentally ill, "private insurance is essentially meaningless. Because of their illness, most are indigent, and private insurance is a luxury they cannot afford and are not in a position to obtain through employment." Of particular significance for the elderly mentally ill, Medicare does not pay for prescription pharmaceuticals, such as those used to control mental illness, and additionally lacks parity between coverage for health and mental health coverage. And despite the promises made under the Mental Health Code that no admission may be limited on the patient's financial status or ability/inability to pay, the fact remains that the number of beds for psychiatric patients has been drastically reduced. In

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After a court determines that a person is subject to involuntary commitment, the court must order the respondent's placement in the least restrictive treatment available. The court has several options at its disposal: ordering hospitalization, ordering outpatient treatment, or ordering the person to be placed in the care of a relative. There is a statutory preference for treatment other than hospitalization. Thus, hospitalization may be ordered if the state proves it is the least restrictive treatment available.

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274. Helen Gunnarsson, Bill Would Make Involuntary Commitment Easier, 95 ILL. B.J. 401, 401 (2007); see Gutterman, supra note 127, at 2434 (discussing involuntary commitment statutes which have been criticized as "'harsh, quick, fixe[s] that [d]o little to address the system's underlying problems' of inadequate funding and services for the mentally ill.")

275. Gunnarsson, supra note 274, at 399.


277. Anita L. Rosen et al., Mental Health Policy and Older Americans: Historical and Current Perspectives, in EMERGING ISSUES IN MENTAL HEALTH AND AGING 1, 9 (Margaret Gatz, ed. 1995). "The lifetime coverage limit on inpatient care in mental hospitals is 190 days: no similar limit exists for inpatient care in general hospitals ...." Id.


279. Gunnarsson, supra note 274, at 401.
Illinois, "[t]here are 1,400 beds for psychiatric patients in state psychiatric hospitals now, compared with 55,000 beds fifty years ago, and fewer than 4,000 private hospital beds. Yet the state's population has doubled in that time." As a result, "[p]eople who are seriously mentally ill and who cannot afford to pay for care out of their own resources are routinely turned away." Additionally, the statutory promise does not extend to follow up care in the community after release from an institution. Increasing restraints on people with mental illness will not improve the mental health system in Illinois; providing funding to ensure their access to long-term, intensive community care will.

**POSSIBLE CONSEQUENCES OF THE AMENDMENT AS WRITTEN**

One possible and unintended result of the Illinois amendment is its impact on the requirements of other laws. Given the statutory definition of an emergency provided by the Examination and Treatment for Emergency Medical Conditions and Women in Labor Act (EMTALA), an indigent person who was experiencing mental and or emotional deterioration and voluntarily sought admission to a hospital would be turned away; then under the same standard he could be forcibly committed by a court. How dangerously ill could a person be

280. Id.
281. Id. at 399.
285. See id.
286. Id.
287. Id.

The term 'emergency medical condition' means—a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual . . . in serious jeopardy, or
if he is denied care under a federal law enacted to provide emergency care? Ill enough to justify confining him against his will?

Further, by lowering the requirement for involuntary commitment to less than what the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires for disclosure of a patient's medical records without his consent, it is possible that Illinois has created a situation in which a person could be involuntarily committed, but his prior medical records could not be released to the institution in which he was confined. Would that not impede the efforts of the medical personnel in their care of him? The amendment has also created a conflict with Illinois law regarding the disclosure of mental health information; will the legislature lower the standards for disclosure to accommodate the law and consequently erode the patient's privacy protections?

Additionally, even patients who are involuntarily committed are presumed to have the capacity to make treatment decisions in Illinois. Has the legislature created a situation in which a person could be admitted under the new, lower standard, but then because he is not incompetent and does not meet the standard for forced treatment, not be treated? Does that not frustrate the purpose behind lowering the standard for involuntary commitment?

If so, will the legislature attempt to lower the standard for forced medication as well? What about for ECT? Since the standards for involuntarily treating patients are similar to the standards for involuntarily treating prisoners and those found not guilty by reason of insanity, lowering the standards for the serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Id.

290. See In re C.E., 641 N.E.2d at 351.
mentally ill could affect a significantly larger class than was originally intended. In establishing this lowered standard, the legislature seems to have failed to consider the impact such a standard would have not just on the mentally ill, but also on those charged with providing them care.

An additional consequence may be that in order to meet the increased demands on the system, the state will reduce procedural safeguards. Amendments passed in 2000 reduced the time a patient could be hospitalized before learning whether he could be forced to receive treatment. This decrease was made in response to limits on the number of days for which insurers would reimburse facilities for inpatient treatment. Might further reductions in spending cause further reductions in procedural safeguards? A reduction in procedural safeguards is contrary to the reasoning the Supreme Court used in Vitek v. Jones, "[i]t is precisely 'the subtleties and nuances of psychiatric diagnosis' that justify the requirement of adversary hearings."

Finally, Illinois had a comparatively low standard for involuntary commitment already, but knowing there was no money to pay for a hospital stay, judges in practice used a higher one. As such, lowering the standard may have no effect at all. Representative Kathleen Ryg acknowledged at legislative hearings that there was no funding to support the


295. Id.

296. Id. at 498. Procedural safeguards are "important in assuring that the initial euphoria over the newest mental health treatments does not cause patients to ... become data for later studies that will reveal the treatments to have less benefit and cause more harm than originally thought." Id. at 498.


298. Gunnarsson, supra note 274, at 401.

299. Id.

300. Id. Judges used the standard "imminent danger." Id.

301. Id.
amendment, stating "one of the positions in opposition to this Bill states that the current standard for involuntary commitment does not ensure that people who meet the standard are actually committed, because state and private hospital beds have been so drastically reduced that it is not a viable treatment option... [but] that is not a reason to be against this legislation." If the state could not afford the standard for involuntary commitment already in place, how is it going to afford one that puts more demands on the system?

CONCLUSION

In 1975, the Supreme Court established a two-part requirement for the involuntary commitment of the mentally ill. Both parts are essential. Recognizing the deprivation of liberty involved in involuntary confinement, the Supreme Court required a legal standard: a person cannot be confined unless he is dangerous. The legal standard is based on foundational principles that do not change. But a legal standard alone does not address the specific issues relating to mental health. Recognizing that mental illness is a disease, the Supreme Court also required a medical standard, to reflect the fact that science and medicine are constantly changing.

Advances in medical science often prove prior theories wrong. But citizens of the United States are free to take advantage of the latest advances, because they can be confident

302. Debate, supra note 57, at 209.
303. Id.
304. See O'Connor, 422 U.S. at 575.
305. Id. at 576
306. Id.
307. See O'Connor, 422 U.S. at 576 ("In short, a State cannot constitutionally confine... a non-dangerous individual who is capable of surviving safely in freedom...") (referring to Fifth and Fourteenth Amendment due process protections).
308. O'Connor, 422 U.S. at 584.
that the legal standard protects them from actions by the state, based on any discredited theories, which would have violated their fundamental rights. If it turns out that the symptoms that accompany mental illness are not inherently dangerous, there will be no factual evidence of danger, and the legal standard will prevent the state from committing in violation of due process. If the behavior that accompanies mental illness is truly dangerous, however, there will be evidence of the danger, and the legal standard will be satisfied. In that case, symptoms can remain symptoms, and danger does not have to be “redefined.”