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Joshua's Children: Constitutional Responsibility for Institutionalized Persons After *DeShaney v. Winnebago County*

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I. Introduction

"Poor Joshua!"[1]

I cried when I read those words. It isn't often that a Justice of the Supreme Court expresses understanding that real people are affected by the Court's rulings, let alone grieves for them. It was an extraordinary moment in a Supreme Court dissent, a heartfelt response to a majority opinion in which the heart played no part.

But, as Claire Hagan's Note[2] makes clear, it is not only in matters of the heart that the majority opinion in *DeShaney v. Winnebago County*[3] falls short. The Supreme Court used *DeShaney* to set out a framework limiting the power of citizens to claim affirmative constitutional rights under the Constitution,[4] but its chosen framework is far less workable than the majority would have us believe. While federal constitutional protections are obviously not boundless, the lines drawn by the Supreme Court have led lower courts to chaotic and inconsistent interpretations and outcomes in cases involving institutionalized individuals.

Ms. Hagan presents this case in a detailed and well-argued piece. She persuasively contends that in deciding *DeShaney,* the Supreme Court set the stage for the inevitable confusion and division among the circuits that continues to this day.

Ms. Hagan begins by describing the *DeShaney* decision, pointing out errors in the assumptions on which the majority

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1. DeShaney v. Winnebago Cnty. Dep't of Soc. Servs., 489 U.S. 189, 213 (1989) (Blackmun, J., dissenting).

2. Claire M. Hagan, Note, *Sheltering Psychiatric Patients from the* DeShaney *Storm: A Proposed Analysis for Determining Affirmative Duties to Voluntary Patients*, 70 WASH. & LEE L. REV. 725 (2013).

3. *DeShaney*, 489 U.S.

4. *See id.* at 199–201 (stating that affirmative constitutional rights arise only when the state, through an affirmative action, restrains a person's liberty, prevents the person from acting on his own behalf, or creates the danger at issue).

based its holding.[5] Then, linking *DeShaney* with the Court's decisions in *Youngberg v. Romeo*[6] and *Zinermon v. Burch*,[7] she surveys the intersection of these cases in six different circuits, summarizing the current divergent approaches to determining the affirmative rights of institutionalized individuals.[8] She gives the reader a sense of how people in psychiatric institutions actually experience their admission and institutional treatment, and she exposes the pretextuality of the concept of voluntariness in the institutional setting.[9] Finally, she proposes a clear test that could be effectively applied by courts in determining whether an institutionalized individual may claim affirmative constitutional rights.[10]

This is an excellent Note, and there is little to disagree with in its approach. My Comment will begin by summarizing what I have learned from almost thirty years of experience about what actually happens in institutional settings.[11] Ms. Hagan accurately sets forth both the coercion and the loss of even the most elementary forms of choice and control represented by life in an institution. These everyday realities of state institutional settings are not commonly known to the public, and while much has improved since I began this work in a law school clinic in 1984, the need to protect patients against abuses unique to the culture of the institutional environment still remains strong in many state facilities.

Although the facilities have improved, the legal barriers to vindicating constitutional rights for institutionalized individuals have actually increased since the early 1980s. Increasingly conservative courts have imposed more and more roadblocks,

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5. *See* Hagan, *supra* note 2, at Part II.B.2–II.C (discussing *DeShaney* and its aftermath).

6. Youngberg v. Romeo, 457 U.S. 307 (1982).

7. Zinermon v. Burch, 494 U.S. 113 (1990).

8. *See* Hagan, *supra* note 2, at Part IV (reviewing the split among the First, Second, Third, Fifth, Sixth, and Eighth Circuits regarding how to analyze whether states owe affirmative duties to voluntary patients).

9. *See id.* at Part V (describing how problems with competency and coercion affect voluntariness).

10. *See id.* at Part VI (setting forth a proposed analysis).

11. *Infra* Part II.

both substantive and procedural, to litigation on behalf of disenfranchised and vulnerable populations. The barrier in some circuits to affirmative constitutional rights for legally voluntary institutionalized patients is one major example of this trend.

In the second part of the Comment, I will do what public interest lawyers in my field have always done: translate the real-life experiences of patients in institutional settings into the formal structure of the law. Ms. Hagan has done an excellent job of surveying the tangled, complex, and contradictory reactions of the circuits to *DeShaney* by describing the leading cases relating to the affirmative constitutional rights of institutionalized psychiatric patients.[12] I will complement her work by examining additional federal and state court cases involving these rights, as well as the most recent caselaw specifically interpreting *DeShaney*.[13] Not surprisingly, the messages from the circuits continue to be at odds with each other, and some circuits do not even have an internally consistent approach. The conflicts in the circuits are so numerous that it's surprising there has not been a Supreme Court follow-up clarifying the interpretation of *DeShaney* in institutional settings.[14]

Finally, I will evaluate Ms. Hagan's proposed standard in light of the standards currently used in the circuits and those that have been recommended in the scholarly literature.[15] Her proposed standard is among the best, if not the best, of the proposals that have been formulated since the *DeShaney* decision to clarify and determine the affirmative constitutional rights of institutionalized individuals.

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12. Hagan, *supra* note 2, at Part IV.

13. *Infra* Part III.

14. Except for sexual offenders and people in the criminal justice system, the Supreme Court has not had a single case on the constitutional rights of people who are civilly committed or voluntary patients in institutions since *Heller v. Doe*, 509 U.S. 312 (1993), and *Zinermon v. Burch*, 494 U.S. 113 (1990), and both were cases involving procedural due process rather than substantive due process. The Supreme Court has not had a substantive due process case involving the rights of institutionalized persons since *Youngberg v. Romeo*, 457 U.S. 307 (1982).

15. *Infra* Part IV.

II. DeShaney *and the Real World of Institutionalized Psychiatric Patients*

First, like Justice Blackmun, I will speak from the heart. I spent almost thirty years as a public interest lawyer representing people with psychiatric disabilities, many of whom were institutionalized. I perennially negotiated the tension between understanding that courts must craft workable rules providing predictability and guidance in myriad situations, and frustration at the artificiality and inadequacy of those rules when applied to the people I represented and the situations in which they found themselves.

Public interest lawyers serve as the intermediaries between their clients' often horrific experiences of injustice and the judges in whose worlds those experiences are impossible to imagine. So we take true stories from a world that is fundamentally alien to a skeptical judiciary, and repackage them as legal claims, omitting the nuances to create a narrative that is meaningful in the judges' language and world, all the while trying to be as faithful as possible to our clients' original experiences. In doing this, we must accept and work with legal doctrines based on assumptions that fly in the face of what we know to be true.

Nowhere was this cognitive dissonance more stark to me than in the doctrinal abyss that some courts have interpreted *DeShaney v. Winnebago County* to require, sharply dividing the residents of institutions.[16] Under these decisions, involuntarily

16. *See, e.g.*, Shelton v. Ark. Dep't of Human Servs., 677 F.3d 837, 840 (8th Cir. 2012) (stating that, under *DeShaney*, a patient's status as voluntary or involuntary determines whether affirmative duties are owed, though recognizing that voluntary status may change during admission); Torisky v. Schweiker, 446 F.3d 438, 444–46 (3d Cir. 2006) (recognizing that under *DeShaney*, states generally do not owe patients affirmative duties, but clarifying that *DeShaney* does not preclude affirmative duties when voluntary patients are not free to leave); Walton v. Alexander, 44 F.3d 1297, 1304 (5th Cir. 1995) (applying *DeShaney* strictly and concluding that states do not owe patients affirmative duties unless "the person is involuntarily taken into state custody and held against his will through the affirmative power of the state"); Monahan v. Dorchester Counseling Ctr., 961 F.2d 987, 991 (1st Cir. 1992) (applying *DeShaney* to mean that a state does not owe affirmative duties unless it restrains a patient's liberty by involuntarily committing him); Higgs v. Latham, 946 F.2d 895 (table), No. 91-5273, 1991 WL 216464, at *4 (6th Cir. Oct. 24, 1991) (per curiam) (applying *DeShaney* as precluding affirmative duties to

committed individuals have affirmative constitutional rights to safety, freedom from unreasonable bodily restraint, and minimally adequate treatment necessary to realize those rights, while legally voluntary patients have no affirmative constitutional rights at all.[17] The rationale for the distinction appears to be the assumption that legally voluntary patients can leave the institution if they are dissatisfied.[18]

I have spent a considerable amount of time inside state institutions in fourteen states and the District of Columbia, and in my experience, there is no difference between the loss of liberty suffered by civilly committed and voluntary patients in state institutions. Nor is there any difference in the control exercised by those institutions over the lives of civilly committed and voluntary patients.[19] Voluntary patients are detained, restrained, contained, secluded, locked up, assaulted, and denied ground "privileges" and visiting passes in exactly the same way as civilly committed patients. Their lives are equally subject to control from the moment they arise in the morning at a preordained time, through meals and cigarette breaks and "groups," to who is permitted to visit and when, to the long stretches of empty hours in the dayhall.

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voluntary patients). *But see* Walton v. Alexander, 44 F.3d 1297, 1306 (5th Cir. 1995) (Parker, J., concurring) ("The Court's holding [that a bright line separates voluntary and involuntary patients] is based on an erroneous reading of the Supreme Court's guidance in *DeShaney*, and draws an arbitrary, illogical, and formalistic line between persons who are entitled to constitutional protection."); Higgs v. Latham, 946 F.2d 895 (table), No. 91-5273, 1991 WL 216464, at *6 (6th Cir. Oct. 24, 1991) (Suhrheinrich, J., concurring) ("I do not read *DeShaney* to control the outcome of this case. . . . [E]ven *DeShaney* compels us to go *beyond asking whether [the patient] was a voluntary admittee*." (emphasis added)).

17. *See* cases cited *supra* note 16 (consistently recognizing that involuntary patients are owed the affirmative duties of care and protection recognized in *Youngberg v. Romeo*); Youngberg v. Romeo, 457 U.S. 307, 324 (1982) (establishing that the affirmative duties applicable to institutionalized patients include "conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests").

18. *See, e.g.*, Monahan v. Dorchester, 961 F.2d 987, 992 (1st Cir. 1992) ("Monahan's complaint did not allege that he would have been barred from leaving [the state facility] upon request.").

19. Like Ms. Hagan, I am excluding the ever-expanding number of forensic patients in state psychiatric facilities from my comments.

Voluntary patients can't leave, and they know they can't leave. Or at least they know they can't leave once they ask to leave. If they ask verbally, they are often told they cannot be released. Sometimes they are given papers to fill out officially requesting release. If they file formal notifications of their intention to leave, they are either "persuaded" to withdraw those notifications or involuntary commitment proceedings are filed against them.

The fact that state commitment statutes operate differently in different states may inform the formal legal analysis, e.g., whether staff is legally obligated to offer patients the opportunity to change their status to voluntary. But on the ground, the picture always looks the same: however a patient gets to a state mental facility, that patient cannot leave until either the institution or a court decides it's time to go.

In addition to being places of total constraint on liberty, which patients cannot leave at will, many institutions are places where use of force and threat of force is rampant and underreported, and where acts of violence that would be crimes in the outside world are covered up or characterized as "patient abuse."[20] Many of the female patients have histories of childhood sexual abuse and trauma that make institutional practices like being put in restraints by male aides particularly excruciating. Patients with histories of sexual abuse are asked to endure pat

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20. *See, e.g.*, Davis v. Rennie, 264 F.3d 86, 93–96 (1st Cir. 2001), *cert. denied*, 535 U.S. 1053 (2002) (reviewing trial testimony and jury verdict in favor of a patient beaten by staff after being restrained); Clark v. Donohue, 885 F. Supp. 1159, 1160 (S.D. Ind. 1995) (involving lawsuit over the death of two patients ages 35 and 40 at state institution claimed to be a result of "severe medical and physical mistreatment"); UNIV. LEGAL SERVS., INC., BEHIND LOCKED DOORS: SAINT ELIZABETHS HOSPITAL 4 (2011) (reporting that in a hospital with 300 patients, there were 388 physical assaults, 10 sexual assaults, 7 suicide attempts and 10 deaths in one year); PROTECTION AND ADVOCACY INC., INVESTIGATIONS UNIT, A SERIES OF SUSPICIOUS GENITAL LACERATIONS AT ONE DEVELOPMENTAL CENTER: DID DDS RESPOND APPROPRIATELY? (2005), http://www.disability rightsca.org/pubs/702101.pdf; *Special Litigation Section Cases and Matters*, U.S. DEP'T OF JUSTICE, www.justice.gov/crt/about/spl/casesummaries.php (last visited Feb. 2, 2013) (linking to documents relating to patient beatings and sexual assaults in hospitals in California, Connecticut, Georgia, New York, Tennessee and Virginia) (on file with the Washington and Lee Law Review).

downs, strip searches, and body cavity searches.[21] Even bed checks, a practice involving staff coming into patients' rooms at night and shining flashlights on their beds to ensure that they are there, can be difficult to endure.

Sexual activity in institutional settings is more common than outsiders might imagine, and runs that gamut from mutual and supportive relationships between patients through exploitation, coercion, and rape by other patients and staff.[22]

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21. *See* Serna v. Goodno, 567 F.3d 944, 947 (8th Cir. 2008), *cert. denied* 130 S. Ct. 465 (2009) (noting that 150 patients institutionalized in Minnesota's Sex Offender Program were subjected to visual body-cavity inspections after a contraband cellphone was found); Aiken v. Nixon, 236 F. Supp. 2d 211, 218, 236 (N.D.N.Y. 2002) (noting that a voluntary psychiatric patient was subjected to a strip search upon admission pursuant to a "standing order," rather than to a reasonable belief that the patient possessed drugs or contraband); Anne Donahue, *Strip Searches: Going Too Far for Safety Needs?*, COUNTERPOINT, July 2009, at 1 (describing policies implemented by some Vermont hospitals to perform mandatory full body searches on patients being admitted to psychiatric units).

22. *See* Ammons v. State Dep't of Soc. & Health Servs., 648 F.3d 1020, 1032 (9th Cir. 2011), *cert. denied* 132 S. Ct. 2379 (2012) (holding that a teenage patient's sexual relationship with a staff member may lead to the facility director's constitutional liability for failure to protect); Beck v. Wilson, 377 F.3d 884, 886–87, 892 (8th Cir. 2004) (concluding that qualified immunity protected state officials in a suit brought by an involuntarily committed raped woman who was the only woman on a ward full of men and had reported being afraid she would be sexually assaulted); Neely v. Feinstein, 50 F.3d 1502, 1505 (9th Cir. 1995) (denying qualified immunity for failure to supervise a staff person who repeatedly sexually assaulted patients); Walton v. Alexander, 20 F.3d 1350, 1353 (5th Cir. 1995) (involving a student at a state-operated residential school who was sexually assaulted by another student on multiple occasions); Rodgers v. Horsley, 39 F.3d 308, 311 (11th Cir. 1994) (per curiam) (concluding that an involuntarily committed pregnant woman raped while on observation cannot recover because of insufficient evidence of past rapes at facility, even though the state was aware of sexual activity at facility); Higgs v. Latham, 946 F.2d 895 (table), No. 91-5273, 1991 WL 216464, at *1–2 (6th Cir. Oct. 24, 1991) (per curiam) (involving a claim by a psychiatric patient who was sexually assaulted by another patient); Davis v. Holly, 835 F.2d 1175, 1177 (6th Cir. 1987) (involving a claim brought by mental patient who had sex with a staff member and gave birth to a child); Elizabeth M. v. Ross, No. 8:02CV585, 2005 U.S. Dist LEXIS 45107, at *4, *7–8 (D. Neb. May 11, 2005) (certifying a class of women subject to rape, sexual assault, sexual harassment, sexual exploitation, and physical assault at three state institutions), *vacated by* Elizabeth M. v. Montenez, 458 F.3d 779, 787–88 (8th Cir. 2006) (finding a lack of typicality in that some women alleged being raped and sexually assaulted by staff and others by other patients, that most of the women were from one institution, and that most had already been discharged); Caroline C. v. Johnson, 174 F.R.D. 452, 455–57 (D. Neb. 1996) (certifying a class of raped and sexually assaulted women

The use of restraints, which varies widely from facility to facility, can result in death or serious injury.[23] In some facilities, patients are tied to beds with "five-point restraints" (arms, legs, and across the chest). In other facilities, they are tied to chairs. Due to a tremendous effort by the Joint Commission,[24] the National Association of State Mental Health Program Directors,[25] and extraordinary dedication in states like Pennsylvania and Massachusetts, some state facilities are virtually restraint-free.[26] But in others, restraint remains commonly used, including daily use on some patients.[27]

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at institution); *see also* Winiviere Sy, *The Right of Institutionalized Disabled Patients to Engage in Consensual Sexual Activity*, 23 WHITTIER L. REV. 545, 546–48 (2001) (discussing policies regarding consensual sexual activities at various California hospitals).

23. *See, e.g.*, Substance Abuse & Mental Health Admin., *Seclusion and Restraint: Statement of the Problem and SAMHSA's Response* (May 2003), www.samhsa.gov/seclusion/sr_handout.aspx (last visited Jan. 30, 2013) ("The use of seclusion and restraints on persons with mental health and/or addictive disorders has resulted in deaths and serious physical injury and psychological trauma.") (on file with the Washington and Lee Law Review); Letter from Grace Chung Becker, Acting Assistant Att'y Gen., U.S. Dep't of Justice, Civil Rights Div., to Rick Perry, Governor, Tex. 17–18 (Dec. 1, 2008), www.justice.gov/crt/about/spl/documents/TexasStateSchools_findlet_12-1-08.pdf.

24. Joint Comm'n, *Sentinel Event Alert: Issue 8, Preventing Restraint Deaths* (Nov. 18, 1998), http://www.jointcommission.org/sentinel_event_alert_issue_8_preventing_restraint_deaths/ (last visited Jan. 30, 2013) (on file with the Washington and Lee Law Review).

25. NAT'L ASSOC. OF STATE MENTAL HEALTH PROGRAM DIRS., NASMHPD'S POSITION STATEMENT ON SECLUSION & RESTRAINT (2007), www.nasmhpd.org/docs/policy/S&R%20position%20statement.Forensic%20Div.%20prop.%20approved%20by%20NASMHPD.07.07.final.pdf ("It is NASMHPD's goal to prevent, reduce and ultimately eliminate the use of seclusion and restraint . . . .").

26. *See, e.g.*, Gregory M. Smith et al., *Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program*, 56 PYSCHIATRIC SERVS. 1115, 1116—17 (2005) (presenting the results of an empirical study that shows dramatic decreases in use of physical restraints in Pennsylvania psychiatric facilities from 1990 to 2000).

27. *See Seclusion and Restraint Practice Standards: A Review and Analysis*, MENTAL HEALTH AMERICA, http://www.ncstac.org/index.php?option=com_content&view=article&id=94%3Aseclusion-and-restraint-practice-standards-a-review-and-analysis&catid=34&Itemid=29 (last visited Jan. 30, 2013) (reviewing various standards used in state hospitals' restraint policies) (on file with the Washington and Lee Law Review).

In sum, Ms. Hagan is correct that institutionalized people are vulnerable and in need of protection; they are also isolated from the oversight of the larger community and the norms of community culture. Institutions develop cultures of their own. Sometimes these are healing; more often they are not. The move to true community integration has begun, but in the meantime, those who are left behind in institutional settings deserve better than to be told that the state is not responsible for their safety because they chose to be in an environment that, in all truth, they cannot escape.

III. Chaos in the Circuits: The Interpretation of DeShaney*'s Application to Institutionalized Patients*

Ms. Hagan's Note accurately summarizes, for the most part, the differences in approaches taken by the circuits in applying *DeShaney* to the affirmative constitutional rights of individuals in state institutions.[28] If anything, she is too tactful to assert just how irrational and counterintuitive these results have been, including conflicting results within the same circuits. This is in part because the *DeShaney* Court was resolving a factual and legal situation far different from the situation of individuals in state institutions.[29] The Court did not specifically address the nuances of voluntary and involuntary institutionalization because those issues were not before it. And yet courts in the various circuits confidently cite *DeShaney* as supporting their divergent approaches to affirmative constitutional rights within institutional settings.[30]

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28. Hagan, *supra* note 2, at Part IV.

29. *See* DeShaney v. Winnebago Cnty. Dep't of Soc. Servs., 489 U.S. 189, 193 (1989) (stating that *DeShaney* involved a person injured by his father while living in the community).

30. *See supra* note 16 (collecting cases that apply *DeShaney* to cases involving state hospital patients).

A. The DeShaney *Decision Is Not Concerned with Institutionalized Individuals*

Although the circuit courts have taken *DeShaney* as a touchstone for determining the affirmative constitutional rights of institutionalized individuals,[31] their interpretations of its direction have diverged considerably. This is not surprising: the Court's comments on institutionalized individuals are delphic and ambiguous because the facts in *DeShaney* did not raise any of the issues involved in institutionalization.

Joshua DeShaney lived at home in the community.[32] He was in the custody of a hospital for less than a week because his injuries prompted review of his father's parental rights.[33] The state's interactions with Joshua amounted to a visit, once a month, by a social worker.[34] It is true that during each of these monthly visits, the social worker could see much that should have been greatly troubling, and that in the last two visits, she did not see Joshua at all.[35] Joshua's father beat him over most of his life, and continued to beat him without state intervention, until Joshua suffered severe and irreversible brain damage.[36]

As horrific as the circumstances of the *DeShaney* case are, they are not analogous in terms of state responsibility and control to the situation of individuals residing in a facility operated by the state, staffed entirely by state employees, whose actions, schedules, and activities are under supervision twenty-four hours a day, who cannot leave the grounds of the facility without a pass, much less decide to leave the facility itself. The community has little or no interaction, oversight, or power to intervene at state hospitals; family visits are often regulated to a few hours a week and in some cases prohibited altogether.[37] An institutionalized

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31. *Supra* note 16.

32. *DeShaney*, 489 U.S. at 193.

33. *Id.* at 192.

34. *Id.* at 192–93.

35. *Id.* at 193.

36. *Id.* at 192–93.

37. *See, e.g.*, Doe v. Pub. Health Trust, 696 F.2d 901, 905–06 (11th Cir. 1983) (Hatchett, J., concurring) (describing a hospital's policy of restricting adolescent patients' ability to communicate with their parents as part of a

individual is entirely in the hands of the state and at its mercy, a situation that could not be more different than that of Joshua DeShaney.

Therefore, it is not surprising that, in rejecting claims of state responsibility for Joshua DeShaney, the Supreme Court was not completely clear about the boundaries of those responsibilities. As Ms. Hagan points out, the Court variously states that affirmative constitutional rights are afforded to "involuntarily committed mental patients,"[38] to "a person [taken] into custody and [held] there against his will,"[39] and to a person who "is institutionalized and wholly dependent on the State."[40]

The majority is clear about one thing: the basis of any state affirmative responsibility must lie in affirmative state action.[41] Neither an individual's vulnerability to harm nor the state's knowledge of both that vulnerability and the risk of private violence to the individual suffice to create affirmative responsibility on the part of the state.[42] Rather, the state must clearly act to restrain the individual's liberty.[43] Ms. Hagan argues, and I agree, that the Supreme Court never intended to limit the evaluation of state action to restrain an individual's liberty to an individual's legal status at admission to a state institution.[44] Rather, the analysis requires an examination of the degree to which the state has acted to replace an individual's

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"privilege" system).

38. DeShaney v. Winnebago Cnty. Dep't of Soc. Servs., 489 U.S. 189, 199 (1989).

39. *Id.* at 199–200.

40. *Id.* at 200.

41. *Id.*

42. *Id.* 200–02.

43. The Court reiterates that the focus must be on the state's action: when the state "by an affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself" the affirmative duties are created. *Id.* A few sentences later, the Court underscores that "it is the State's affirmative act of restraining the individual's freedom to act on his own behalf—through incarceration, institutionalization, or other similar restraint of personal liberty—which is the 'deprivation of liberty' triggering the protections of the Due Process Clause, not its failure to act to protect his liberty interests against harms inflicted by other means." *Id.*

44. Hagan, *supra* note 2, at 786–87.

ordinary control of his or her own life with its own control, regardless of the individual's own wishes and desires. Ms. Hagan's question to judge the state's control over an individual—can the individual leave state custody, or be taken from state custody by caring family and friends, or would the state prevent or prohibit those actions?[45]—is the right one, with the right results.

B. The Patient's Legal Status on Admission as Voluntary or Involuntary as Determinative of Constitutional Rights

As Ms. Hagan notes, some circuits have chosen to rely primarily on a patient's formal legal status at the time of admission to the institution to determine whether the individual is entitled to assert constitutional rights to safety and bodily security,[46] although even these circuits recognize the state-created danger, "special relationship," and other exceptions, and many of the circuits also have intracircuit conflicts.

Those circuits that rely primarily on the legal status of the patient may initially appear to have chosen a framework that at least allows for clarity and certainty.[47] But even if that was the case, the test is not rational and leads to unjust results.

It is not rational for a number of reasons. First, it bears no relationship to the Supreme Court's underlying explication of its own standard in *DeShaney*. According to the majority, the reason that the state owes affirmative obligations when it deprives an individual of liberty against his will and places the individual in an institution is that the state has deprived the individual of the ability to provide for his or her own needs.[48] This, as both Ms. Hagan and Justice Brennan's *DeShaney* dissent underscore, is a

45. *Id.* at Part VI.

46. *Id.* at Part VI.A.

47. It actually is not so simple. *See infra* notes 90–101 and accompanying text.

48. *See* DeShaney v. Winnebago Cnty. Dep't of Soc. Servs., 489 U.S. 189, 200 (1989) ("[W]hen the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs . . . it transgresses the substantive limits on state action.").

whopping legal fiction.[49] Nicholas Romeo, the plaintiff in *Youngberg v. Romeo*, was described as being "profoundly [mentally] retarded"[50] and was no more able to fend for himself without help than Joshua DeShaney, regardless of his legal status.

Second, Ms. Hagan points out that some voluntary patients are not actually competent to provide informed consent to hospitalization.[51] In fact, she notes that the Supreme Court itself has held that states should foresee the possibility that voluntary patients may be incompetent to execute valid consents to hospital admission and treatment.[52] Circuits have similarly considered cases in which the patients appear incompetent to consent to voluntary admission,[53] especially in the area of people institutionalized with developmental disabilities.[54] There is a substantial research literature going back over thirty years, but increased after the Supreme Court's decision in *Zinermon v. Burch*, underscoring the alarming percentage of voluntary

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49. *Id.* at 206 (Brennan, J., dissenting).

50. Youngberg v. Romeo, 457 U.S. 307, 309 (1982).

51. Hagan, *supra* note 2, at Part V.A.

52. Zinermon v. Burch, 494 U.S. 113, 134, 136 (1990).

53. In addition to the material cited by Ms. Hagan, *supra* note 2, at Part V.A, see Wilson v. Formigoni, 42 F.3d 1060, 1062–63 (7th Cir. 1994) (reviewing hospital documentation, where staff persuaded patient to sign in as voluntary even though her intake assessment noted that she "lacked decision making abilities, as well as appearing to be delusional" and "was only partially oriented" and "her thought process was fragmented"); Rennie v. Davis, 997 F. Supp. 137, 138–39 (D. Mass. 1998), *aff'd sub. nom.* Davis v. Rennie, 264 F.3d 86 (1st Cir. 2001), *cert. denied* 535 U.S. 1053 (2002) (finding that the patient's medical record evidenced that he was mentally incapacitated at the time hospital staff allowed him to sign a voluntary admission form); Butler v. Comm'r of Mental Health, 463 F. Supp. 806, 807 (E.D. Tenn. 1978) (describing plaintiff's allegations that she was taken to a hospital against her will and never knowingly signed any voluntary admission forms although the hospital had her listed as a voluntary patient).

54. *See, e.g.*, United States v. Tennessee, 615 F.3d 646, 648, 650 (6th Cir. 2010) (describing Tennessee laws allowing parental consent to substitute for a patient's consent to voluntary treatment for institution serving patients with mental retardation); Doe v. Austin, 848 F.2d 1386, 1388–89 (6th Cir. 1988) (describing Kentucky's comprehensive statutory regime designed to safeguard patients with mental retardation from involuntary commitment, but that parental consent was used to obtain voluntary admission for "virtually all" patients).

patients who have little or no understanding of the documents they have signed.[55] Some state statutes explicitly contemplate noncompetent "voluntary" commitments.[56]

A related, but distinct, issue is whether even competent patients exercise informed consent when they agree to voluntary hospitalization. An individual may be competent but not have sufficient information to make a decision. For example, Massachusetts law requires that a patient seeking voluntary status be given the opportunity to consult an attorney on the benefits and drawbacks of such a decision,[57] while Wisconsin requires that a guardian ad litem visit some voluntary patients within the first three days of admission.[58] In New Jersey, concerns about competence in the context of voluntary admissions led to a statutory requirement that people who want to be voluntary patients must have hearings, with legal counsel, to ensure their decisions are competently made.[59]

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55. Donald H. Stone, *The Benefits of Voluntary Inpatient Psychiatric Hospitalization: Myth or Reality?*, 9 B.U. PUB. INT. L.J. 25, 42–48 (1999) (discussing studies of competency levels and voluntary admissions).

56. Wisconsin, for example, has a category of commitment called "non-protesting voluntary admission" that "usually . . . involves a catatonic or paranoid person who is unwilling to sign an admission form but who does not object to the admission[, or] an elderly confused person with mental illness who needs to be transferred from a nursing home to a psychiatric unit." Diane Greenley, *Civil Commitment and Voluntary Treatment*, *in* RIGHTS & REALITIES II 352 (Wis. Disability Rights ed. 2008), http://www.disability rightswi.org/wp-content/uploads/2008/09/civil-commitment-voluntary-treatment.PDF (citing WIS. STAT. § 51.10(4m)(b) (2012) (providing that a non-protesting "voluntary" admission is only good for seven days)).

57. MASS. GEN. LAWS ch. 123, § 10 (2012); *see also* Rennie v. Davis, 997 F. Supp. 137, 139 (D. Mass. 1998) *aff'd on other grounds*, Davis v. Rennie, 264 F.3d 86 (1st. Cir. 2001), *cert. denied* 535 U.S. 1053 (2002) (concluding that the hospital violated a patient's due process when it failed to inform him of his legal rights under ch. 123, § 10 before the patient executed an application for voluntary admission).

58. WIS. STAT. 51.10(4m)(c) (2012) (requiring that a guardian ad litem visit any patient admitted as a non-protesting voluntary patient within seventy-two hours).

59. N.J. Ct. R. 4:74-7 (2012); *see also* Matter of Commitment of G.M., 526 A.2d 744, 745 (Ch. Div. 1987) ("What good is all our effort in preventing patients from being 'lost in the cracks' if such a hapless category as the so-called 'volunteers' is subject to being lost?").

Ms. Hagan also accurately describes the coercion that many hospitals employ to pressure patients into voluntary status.[60] In many states, patients have a statutory right to elect voluntary hospitalization rather than be involuntarily committed; in discussing this right, courts have continually noted that although technically voluntary, the patients can be prevented from leaving if they give any indication that they want to be discharged.[61] Doctors also sometimes improperly condition granting voluntary status on patient concessions such as agreeing to take medications.[62]

Fourth, a substantial number of patients are voluntary only as a legal technicality, including minors, individuals under guardianship, and individuals in the custody of state agencies, who can be voluntarily admitted by their parents or guardians, or even their health care proxies.[63] This was the case in *Kennedy v. Schafer*,[64] described at length by Ms. Hagan,[65] and in numerous other cases.[66]

However, the most important reason that the voluntary–involuntary distinction has no traction is that, both as a matter of fact and as a matter of law in every state, admission status makes no difference in a patient's liberty and ability to leave once institutionalized. Even if they are completely able to provide for

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60. *See* Hagan, *supra* note 2, at Part V.B (discussing coercive forces in inpatient psychiatric care).

61. *See, e.g.*, Acting Sup't of Bournewood Hosp. v. Baker, 431 Mass. 101 (2000); *In re* Lesley B., 567 N.Y.S.2d 999, 1000 (N.Y. Sup. Ct. 1991).

62. Stone, *supra* note 55, at 46.

63. Cohen v. Bolduc, 435 Mass. 608, 610 (2002) (noting that a patient was involuntarily detained and the health care proxy changed the patient's status to conditional voluntary).

64. Kennedy v. Schafer, 71 F.3d 292 (8th Cir. 1995), *cert. denied*, 116 U.S. 2548 (1996).

65. Hagan, *supra* note 2, at Part IV.B.2.

66. *See, e.g.*, Shelton v. Ark. State Hosp., 677 F.3d 837 (8th Cir. 2012); Z.T. v. Florida, No. 3:10-cv-672-J-20JBT, 2011 WL 5024640, at *4 (M.D. Fla. Oct. 20, 2011) ("In Petitioner's case, though he may have objected to his placement, it was not involuntary for Baker Act purposes [when he was 'voluntarily' placed by the Department of Children and Families, his legal custodian]."); Clark v. Donohue, 885 F. Supp. 1159 (S.D. Ind. 1995); Jordan v. Tennessee, 738 F. Supp. 258 (M.D. Tenn. 1990); Doe v. Pub. Health Trust of Dade Cnty., 696 F.2d 901, 902 (11th Cir. 1983).

their own needs, so-called voluntary patients are no more free to simply walk out the door and provide for those needs than involuntarily committed patients. A district court in Illinois cogently explained the distinction between voluntary legal status and the kind of liberty that the Supreme Court incorrectly assumed that legal status conferred:

> When an individual signs into a mental health facility run by the state, that patient may be consenting to treatment, but the patient is also being committed under the control of the state. The state may restrict the patient's freedom to act, although the patient volunteered for this treatment. The nature of the discretion afforded state officials may be extensive because of the patient's voluntary act, but the court is not convinced that the discretion of state officials is wide enough to sanction the deliberate indifference to the patient's medical needs, or the patient's right to safe conditions, while the patient is incapacitated or restrained in the mental health facility.[67]

In all states, voluntary patients who decide to leave are subject to involuntary holds while institutional personnel attempt to persuade the patient to change his or her mind, and failing that, to decide whether to file for involuntary commitment. In virtually all cases where a voluntary patient files a notice of intention to leave, the hospital pressures the patient to reconsider, and as caselaw confirms, the hospital is frequently successful.[68] If a patient continues to insist on leaving, the hospital counters by filing a petition for involuntary commitment. This is a reality of which patients are well aware. The *DeShaney* Court's rationale that voluntary patients freely choose to avail themselves of the state's services, and can choose to leave at any time, is fundamentally undermined by state laws permitting the involuntary detention of any patient—regardless of legal status—who expresses a desire to leave, until an involuntary commitment

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67. Estate of Cassara v. Illinois, 853 F. Supp. 273, 279 (N.D. Ill. 1994).

68. Wilson v. Formigoni, 42 F.3d 1060 (7th Cir. 1994); Higgs v. Latham, 946 F.2d 895 (table case), No. 91-5273, 1991 WL 216464, at *6 n.1 (6th Cir. Oct. 24, 1991) (Suhrheinrich, J., concurring) (stating that a voluntary patient repeatedly requested to be discharged and was refused); Rennie v. Davis, 997 F. Supp. 137, 139 (D. Mass. 1998) (describing the numerous times the patient signed a form indicating his desire to leave and was pressured to withdraw it by staff).

petition can be filed. As the Sixth Circuit pointed out in *Lanman v. Hinson*:[69]

> In the present case even though Lanman was technically voluntarily committed, under Michigan law, once he gave the hospital notice of his intent to leave, the hospital could retain him against his will for up to three days. . . . [A]pplying the district court's reasoning, if Lanman had decided to leave the hospital, and been retained involuntarily under § 330.1419(1), any § 1983 claims arising in those three days of involuntary confinement would fall under the Fourteenth Amendment. But immediately prior to his decision to leave, while his confinement was technically voluntary, the Fourth Amendment would apply to any § 1983 claims. Under such a system, while Lanman's relationship and dependence on the state would not have changed, his constitutional protection would have. We do not believe such a distinction is warranted.[70]

Lanman is typical of a number of cases in which the court puzzles over the constitutional significance of the legal status of "voluntary" applied to a patient whose injury occurs while actually physically restrained or locked in a seclusion room.[71] In fact, the majority of cases involving patients who are voluntary and supposedly free to leave involve plaintiffs who are secluded in locked rooms, injured or killed in restraints, under continual or virtually continual observation, raped or sexually assaulted, or some combination of these.

The district court in *Estate of Cassara*[72] aptly noted that a patient in seclusion or restraints, even one whose legal status is that of a "voluntary" patient, is not actually free to leave:

> Moreover, that Cassara was placed by the Mental Health Center's staff in a room that is used for restraining patients under guidelines established by state statute suggests a state restriction on liberty in a custodial, institutional setting. Although not specifically alleged, it is a reasonable inference to draw that Cassara may not have been free to leave the

69. Lanman v. Hinson, 529 F.3d 673 (6th Cir. 2008).

70. *Id.* at 683 (citations omitted).

71. *See, e.g.*, *Cassara*, 853 F. Supp. at 273; Davis v. Rennie, 264 F.3d 86 (1st Cir. 2001), *cert. denied* 535 U.S. 1053 (2002).

72. *Cassara*, 853 F. Supp. at 273.

> facility immediately if he had requested to do so. The court finds little practical difference between a locked jail cell and a locked restraint room under the circumstances alleged here. Although Cassara was purportedly free to leave at any time—even while in the restraint/seclusion room—it is not clear that he could merely walk out of the Mental Health Center without the state affirmatively consenting to or allowing his egress. Cassara may have had access figuratively to the key to his cell. The right to leave, however, does not guaranty the *power* to leave.[73]

In addition to being unwarranted and leading to irrational results, the distinction between formal involuntary and voluntary commitment status does not even confer the virtue of clarity, as demonstrated by a number of cases.

Ms. Hagan discusses the Sixth Circuit struggling with real world circumstances in *Higgs v. Latham*.[74] In that case, Ms. Higgs was involuntarily detained by court order, but due to clerical errors and omissions related to her transfer, the staff at Western State Hospital thought she was a voluntary patient.[75] Despite this, staff repeatedly refused her requests to leave.[76] The Sixth Circuit concluded that because Western State did not know of the court's order to involuntarily detain her, she had no constitutional right to security and safety, and therefore her constitutional rights were not violated when she was raped by another patient.[77] It is clear from the Sixth Circuit's decision that if Western State had understood she was an involuntary patient, she would have had a constitutional right to be protected from rape at the State Hospital.[78] And yet Western State would not

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73. *Id.* at 279.

74. Higgs v. Latham, 946 F.2d 895 (table), No. 91-5273, 1991 WL 216464 (6th Cir. Oct. 24, 1991) (per curiam). It should be noted that at the time Higgs was decided, it was denominated as a decision which should not be given precedential value. The Sixth Circuit discussed this issue later in *United States v. Tennessee*, 615 F.3d 646, 653–54 (6th Cir. 2010), noting that, as an unpublished decision, *Higgs* did not bind the court in later decisions.

75. *Higgs*, 1991 WL 216464, at *1–2.

76. *Id.* at *6 n.1 (Suhrheinrich, J., concurring).

77. *Id.* at *5 (majority).

78. *See id.* at *4 ("[T]he hospital was unaware of any commitment order and had been led by a telephone referral to believe that Mrs. Higgs' admission would be a voluntary one.").

have treated her differently in any way whether she was legally involuntary or voluntary; she was no more free to leave in either case.

In another case, *Davis v. Rennie*,[79] the court was faced with a plaintiff who had signed an application for voluntary admission.[80] However, the top of the form contained the typed notation: "the patient refused to sign a voluntary saying, 'I don't want to be here for a year.'"[81] In addition, as plaintiff pointed out, he had been transferred to the state hospital from a private hospital because he was acutely psychotic, so much so that the transferring psychiatrist testified he could not possibly have been competent to sign a voluntary admission on the day he arrived.[82] The state pointed out that after signing the voluntary admission, Mr. Davis had also executed four forms indicating his intention to leave the hospital, and then retracted them, arguing that those repeated retractions clearly indicated that he was actually a voluntary patient.[83] The court rejected this argument as well because Mr. Davis had not been provided with statutorily mandated protections for individuals retracting their intent to leave the hospital.[84]

Yet in a case decided earlier by the highest state court in Massachusetts, the estate of a patient who had been involuntarily committed to a state facility by a court, and then apparently converted to voluntary status, was found to have no affirmative federal constitutional rights to safety or protection because, even though she had been involuntarily committed, she had been converted to voluntary status prior to her death.[85] No inquiry was made regarding the competence of her decision or whether she

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79. Davis v. Rennie, 997 F. Supp. 137 (D.Mass. 1998), *aff'd on other grounds*, 264 F.3d 86 (1st Cir. 2001), *cert. denied* 535 U.S. 1053 (2002).

80. *Id.* at 138.

81. *Id.*

82. *Id.*

83. *Id.* at 139.

84. *Id.*

85. *See* Williams v. Hartman, 597 N.E.2d 1024, 1028 (Mass. 1992) ("Because the decedent was committed voluntarily to Fuller, she did not possess the Federal constitutional rights that the defendant allegedly violated.").

was afforded the rights guaranteed to voluntary patients under any Massachusetts statute.[86]

As is underscored by all of these decisions, a patient's clinical and legal status can change a number of times during a single hospitalization, from voluntary to involuntary and back to voluntary, just as a patient can be incompetent on admission and regain competence during the admission.[87]

None of this, however, has any impact on how a patient is treated, the liberty he or she has while in the hospital, or the patient's freedom to leave. As Ms. Hagan notes, in *Higgs v. Latham* the hospital's misunderstanding about the nature of a patient's legal status made absolutely no difference in the patient's actual liberty or control over her circumstances.[88] Although the hospital thought Ms. Higgs was voluntary, she was still repeatedly told that she couldn't leave when she asked to be released.[89] Yet in *Higgs v. Latham*, as in numerous other cases, Ms. Higgs was denied the constitutional rights that she would have had if the hospital had known that she was involuntarily committed. Civilly committed patients have a panoply of rights (safety, freedom from unreasonable bodily restraint, and minimally adequate treatment) that are substantially different from the constitutional rights of so-called voluntary patients (nothing).

Well, not exactly nothing. As Ms. Hagan points out, there are numerous divisions and splits both among circuits and arguably within the same circuit, as courts struggle to interpret *DeShaney* and to create a framework that is both clear and rational to explain the degree of state involvement necessary for individual injuries to trigger constitutional remedies.

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86. *See id.* at 1027–28 (containing the court's analysis); *id.* at 1028–29 (O'Connor, J., concurring in part and dissenting in part) (arguing that the question of whether the decedent was a voluntary patient should be remanded, because "[m]any critical factual questions remain unanswered").

87. Stone, *supra* note 55, at 31–40.

88. Hagan, *supra* note 2, at 782.

89. Higgs v. Latham, 946 F.3d 895 (table case), No. 91-5273, 1991 WL 216464, at *6 n.1 (6th Cir. Oct. 24, 1991) (Suhrheinreich, J., concurring).

C. Functional Custody: An Alternative to Formal Legal Status in Determining the Affirmative Constitutional Rights of Institutionalized Patients

The Sixth Circuit provides a particularly good illustration of how courts struggle to fit the round peg of reality into the square hole of formal doctrine. *Higgs v. Latham*, and several previous district court cases involving individuals with intellectual disabilities[90] strictly followed the voluntary/involuntary distinction to preclude individual claims of damages for injury and death by plaintiffs who were voluntarily admitted to state institutions. Yet both before and after these cases, the Sixth Circuit found—in *Doe v. Austin*[91] and in *United States v. Tennessee*[92]—that class actions involving individuals with intellectual disabilities voluntarily committed by their guardians *did* state claims for constitutional violations.[93]

In both class actions, the Sixth Circuit followed a rationale that would have applied equally well in the individual-patient cases: it looked beyond formal legal status, concluding that severely disabled individuals "voluntarily" hospitalized by their parents or guardians were not, in fact, as a practical matter free to leave, both because of their own circumstances and the requirements of state law, and that they should therefore be considered involuntary for purposes of their affirmative constitutional rights.[94] This is a classic example of the "functional custody" analysis advocated by Ms. Hagan.[95]

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90. Duvall v. Cabinet for Human Res., 920 F. Supp. 111 (E.D. Ky. 1996); Jordan v. Tennessee, 738 F. Supp. 258 (M.D. Tenn. 1990).

91. Doe v. Austin, 848 F.2d 1386 (6th Cir. 1988).

92. United States v. Tennessee, 615 F.3d 646 (6th Cir. 2010).

93. *Austin*, 848 F.2d at 1395; *Tennessee*, 615 F.3d at 655.

94. *See Austin*, 848 F.2d at 1388 ("[T]he commitment of mentally retarded adults by the Commonwealth upon application by a parent or guardian is to be considered voluntary."); *Tennessee*, 615 F.3d at 651–52 (affirming that the circuit's law had not changed from a prior ruling in this class action litigation, where the circuit held that voluntary and involuntary patients in a facility treating developmental disabilities enjoy identical rights (citing United States v. Tennessee, 798 F. Supp. 483, 486 (W.D. Tenn. 1992))).

95. Hagan, *supra* note 2, at Part VI.A.

The only distinction among these cases appears to be procedural: individual claims versus class actions. However, in another class action, after *Doe* but prior to *Tennessee*, another district court felt bound by *Higgs v. Latham* to exclude constitutional claims of institutionalized individuals with mental retardation and psychiatric diagnoses who were voluntarily placed in the institution by their guardians.[96]

The First Circuit provides another example of confusion within the circuits regarding the boundaries of functional custody. Ms. Hagan describes *Monahan v. Dorchester*,[97] presaged by an even stricter reliance on the voluntary–involuntary distinction by the state's highest court.[98] Yet the First Circuit later affirmed a substantial damage judgment to a patient, admitted pursuant to a voluntary admission form, against staff members who had beaten him after he was restrained, and against their supervisor who did nothing to stop them.[99] Even though the patient was technically voluntary, the district court had refused to dismiss the case because the patient had not been afforded the rights provided under a Massachusetts statute, which allows voluntary patients to consult with an attorney prior to withdrawing a petition to leave the facility.[100] This finding was not pursued on appeal.[101]

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96. Martin v. Voinovich, 840 F. Supp. 1175, 1207 (S.D. Ohio 1993).

97. Monahan v. Dorchester Counseling Ctr., 961 F.2d 987 (1st Cir. 1992).

98. Williams v. Hartman, 413 Mass. 398, 403 (1992) ("[A] patient who is voluntarily committed to a State mental health facility does not possess the same Federal constitutional rights as an involuntarily committed patient.").

99. *See* Davis v. Rennie, 264 F.3d 86, 91 (1st Cir. 2001) (affirming a judgment awarding $100,000 in compensatory damages plus $1,550,000 in punitive damages), *cert. denied* 535 U.S. 1053 (2002).

100. *Id.* at 92–96.

101. *Id.* at 91 (stating the grounds for appeal).

D. State-Created Harm and State Increase of Danger in the Context of Institutionalized Patients

1. Actions by State Actors versus Private Individuals

One crucial limitation of *DeShaney* is that it applies only to the state's responsibility to protect a citizen from the violence or harm of a private citizen. State actors who directly harm a citizen (as opposed to failing to protect him or her) or deprive the citizen of liberty are not shielded by *DeShaney*: *DeShaney* is simply not relevant to cases claiming violence or deprivation of liberty by state actors. The Constitution's "charter of negative liberties" is explicitly aimed at protecting citizens from arbitrary denials of life, liberty, and property at the hands of state agents.[102]

This has been a key distinction in many cases. For example, the panel in *Lanman v. Hinson* found that the central distinction with *Higgs* was that in the latter case, Ms. Higgs was raped by another patient—a third party—while in *Lanman*, state agents were charged with having killed Mr. Lanman during a restraint.[103] This distinction—whether the party causing the harm is a state agent or a private party—has been cited by other courts to find that plaintiffs have stated a constitutional claim.[104]

The distinction is, in fact, useful in cases like *DeShaney* or in cases involving school children that take place in the free world. The state should be responsible for the constitutional violations of its own actors, regardless of the legal status of the institutionalized patient or even whether an individual is institutionalized at all. It is state responsibility for protecting against private violence that must be limited in some way. The Supreme Court has chosen to limit it by confining liability to

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102. *See* DeShaney v. Winnebago Cnty. Dep't of Soc. Servs., 489 U.S. 189, 196 (1989) (stating that the purpose of the Due Process Clause "was to protect the people from the State, not to ensure that the State protected them from each other").

103. Lanman v. Hinson, 529 F.3d 673, 682 n.1 (6th Cir. 2008).

104. Doe v. Covington Sch. Dist., 675 F.3d 849, 855 n.3 (5th Cir. 2012) (en banc); Woods v. G.B. Cooley Hosp. for Retarded Citizens, No. 07-0926, 2007 U.S. Dist LEXIS 74760, at *7 n.2 (W.D. La. Aug. 22, 2007); Clark v. Donohue, 885 F. Supp. 1159, 1162 (S.D. Ind. 1995).

cases in which the state created or exacerbated the danger, or has limited or restrained the liberty of the individual in ways that preclude the individual or others from protecting himself or herself.[105]

Both of these exceptions are at work in the closed setting of an institution. The distinction between private parties and state agents, so useful in the world at large, breaks down when the boundaries of the patient's world—a world from which no exit is possible without state consent—are completely within state-owned, state-staffed, state-supervised, and state-operated property. Unlike the outside world, other patients are not unconstrained, unsupervised free agents. Other patients are there precisely because a mental health professional, and often more than one, has made a judgment that they are not safe to live unsupervised and free lives. Other patients are there to be assessed, receive treatment, and supervision. Staff is generally well aware of the proclivities and risks posed by various patients: that is the purpose of confinement in a state institution. In such close quarters, where neither voluntary nor involuntary patients are in a position to escape the aggression of others, the responsibility of the state to protect may depend, as it does in prison settings,[106] on the degree to which the staff is aware of the inclinations and characteristics of particular patients. If a particularly vulnerable patient is deliberately or recklessly placed in harm's way, the state may be seen to have created or increased the danger that ultimately befalls the patient.

2. State-Created or -Exacerbated Harm in the Context of Suicidal Patients

A number of cases that raise questions about the state's affirmative duties to protect individuals arise in the context of suicide, either in the community after or during a police

105. *DeShaney*, 489 U.S. at 201 & 201 n.9.

106. *See* Farmer v. Brennan, 511 U.S. 825, 837 (1994) (defining the standard for holding prison officials liable for private harm as requiring that "the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference").

encounter, or in institutional settings. The police cases usually raise the question of whether police intervention escalated or increased the danger of suicide; courts' analyses of these cases—which tend to be sympathetic to police actions under circumstances perceived to be both exigent and complex—often focus heavily on the fact that the individual was not in state custody.[107]

When the individual *is* in state custody, the duty to protect raises different issues. When Deborah Shelton was cut down after being found hanging, she was still alive, but state hospital nurses refused to perform mouth to mouth resuscitation without protective masks, which were unavailable at the time, a refusal which was permitted by hospital policy.[108] The state did not have to respond to this issue, because the Eighth Circuit decided that Deborah Shelton, as a "voluntary" patient, had no rights.[109] Of course, Deborah Shelton was no more free to leave the hospital than any involuntarily committed patient.

Although I am a strong advocate of limiting the liability of mental health professionals for the suicide of their patients,[110] like many courts, I draw a distinction between institutionalized patients and patients who live in the community.[111] Even in institutions, the legal issues around suicide revolve not so much around the difference between voluntary and involuntary patients as around the difficulty in determining which patients are truly at risk of suicide, given the small proportion of people with suicidal ideation who actually commit suicide, and the drawbacks of the preventive methods that are implemented to

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107. Cutlip v. City of Toledo, No. 10-4350, 2012 U.S. App LEXIS 13753, at *14–19 (6th Cir. July 5, 2012); Ewolski v. City of Brunswick, 287 F.3d 492, 506 (6th Cir. 2002).

108. Shelton v. Ark. State Dep't of Human Servs., 677 F.3d 837, 839 (8th Cir. 2012).

109. *Id.* at 842.

110. SUSAN STEFAN, RATIONAL SUICIDE, IRRATIONAL LAW (Oxford University Press, *forthcoming* 2014).

111. Mulhern v. Catholic Health Initiatives, 799 N.W.2d 104 (Iowa 2011) (collecting cases).

prevent suicide or self-harm, such as involuntary commitment and physical restraints.[112]

IV. Ms. Hagan's Proposed Standard of Analysis

Ms. Hagan ends her Note with a proposed standard analyzing whether an institutionalized person has stated a constitutional claim that is clear and rational. She proposes that courts examine a claim in three steps that parallel the language of *DeShaney* itself:

1. Is the person involuntarily in the custody of the state as a formal legal matter?
2. Is the person involuntarily in the custody of the state as a functional matter?
3. Has the state created or exacerbated the danger or harm that the plaintiff experienced?[113]

Besides its clarity, Ms. Hagan's standard makes sense. Her standard revolves around the state's own actions in restraining the liberty of individuals or creating or exacerbating a dangerous condition,[114] not around the mental condition or disability of the plaintiff, over which the state has no control.

In determining whether the state exercises functional custody over the individual, Ms. Hagan proposes the standard used in determining whether an individual is in custody for purposes of Fourth Amendment doctrine: would a reasonable individual believe that he or she was free to leave?[115] This test is supported by the language of case law, including *DeShaney* itself: the majority expressed the exception to the absence of any affirmative duty under the Constitution as existing "when the State takes a person into its custody and holds him there against

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112. *See also* Phyllis Coleman & Ronald Shellow, *Suicide: Unpredictable and Unavoidable—Proposed Guidelines Provide Rational Test for Physician's Liability*, 71 NEB. L. REV. 643 (1992).

113. Hagan, *supra* note 2, at Part VI.

114. Ye v. United States, 484 F.3d 634, 637 n.1 (3d Cir. 2007) (explaining that the state's physical custody of the individual is a key factor).

115. Hagan, *supra* note 2, at 787–88.

his will."[116] Subsequent cases frequently equate the question of whether a person is in custody with whether a reasonable person in his or her situation would feel free to leave.[117] The Supreme Court has also equated custody with freedom to leave.[118] Even if a person was too disabled to leave by himself or herself, the question could just as easily be asked: could a caring family member or friend simply drive up and remove him or her from state care? If the answer is yes, then there is no state obligation.

This standard is appropriately limited. Under her proposed standard, as she notes, the plaintiff in *Monahan v. Dorchester* would not have prevailed, while Joyce Higgs and Deborah Shelton would have been allowed to proceed with their claims.[119] Psychiatrically or developmentally disabled individuals in community settings can virtually always move out; no state has created a statutory opportunity to detain and commit an individual who wishes to leave a community residential setting. But in all states a voluntary patient who wishes to leave a state institution can be legally detained and prevented from doing so.

Although there are a number of articles criticizing the analytical chaos created by *DeShaney*,[120] few of these focus on individuals in psychiatric institutions,[121] and, of those, only one

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116. DeShaney v. Winnebago Cnty. Dep't of Soc. Servs., 489 U.S. 189, 199–200 (1989).

117. Ewolski v. City of Brunswick, 287 F.3d 492, 506 (6th Cir. 2002) (stating that a man in a hostage situation whose house was surrounded by police would not feel free to leave).

118. United States v. Drayton, 536 U.S. 194, 204 (2002) ("Nothing . . . would suggest to a reasonable person that he or she was barred from leaving the bus or otherwise terminating the encounter."); California v. Hodari D., 499 U.S. 621, 627–28 (1991) ("[A] person has been 'seized' within the meaning of the Fourth Amendment only if, in view of all the circumstances surrounding the incident, a reasonable person would have believed that he was not free to leave." (citations omitted)).

119. Hagan, *supra* note 2, at 782.

120. *See, e.g.*, Julie Shapiro, *Snake Pits and Unseen Actors: Constitutional Liability for Indirect Harm*, 62 U. CIN. L. REV. 883 (1994); Karen M. Blum, DeShaney: *Custody, Creation of Danger, and Culpability*, 27 LOY. L.A. L. REV. 35 (1994).

121. *See, e.g.*, Teresa Cannistraro, *A Call for Minds: The Unknown Extent of Societal Influence on the Legal Rights of Involuntarily and Voluntarily Committed Mental Health Patients*, 19 ANNALS HEALTH L. 425 (2010).

other author has proposed a standard for interpreting *DeShaney* in this context.[122] Sarah Kellogg endorses the standard suggested by the concurrence in the Fifth Circuit case of *Walton v. Alexander*, which called for a replacement of the voluntary–involuntary analysis with a "special relationship" standard, measured by:

> 1. the authority and discretion state actors have to control the environment and the behavior of the individuals in their custody;
> 2. the responsibilities assumed by the State,
> 3. the extent to which an individual in state custody must rely on the State to provide for his or her basic needs, and
> 4. the degree of control actually exercised by the state in a given situation.[123]

I don't disagree with this formulation: like Ms. Hagan's proposal, it focuses on the situation of the person once he or she is in custody or in the institution, rather than focusing entirely on the process by which he or she ended up in state custody. A person can call a police officer for help, and end up under arrest; the fact that the individual initiated the encounter does not dictate whether he or she is free to leave. No more does the fact that a person may have initially sought help from the state have any bearing on whether that institutionalized individual has any prospect of leaving the hospital through his or her volition alone. While both Ms. Kellogg's standard and Ms. Hagan's standard address this crucial problem with interpreting *DeShaney*, Ms. Hagan's proposal is more clear and provides more guidance.

V. Conclusion

There is no sign that the federal appellate courts are closer to congruence and harmony in their interpretations of *DeShaney*

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122. Sarah C. Kellogg, Note, *The Due Process Right to a Safe and Humane Environment for Patients in State Custody: the Voluntary/Involuntary Distinction*, 23 AM. J.L. & MED. 339 (1997).

123. *Id.* at 358.

and its instructions on limiting affirmative constitutional rights. Ms. Hagan's Note is timely and helpful in proposing an interpretive structure that would be more just and certainly clearer than the current caselaw. She is to be congratulated on a thoughtful and well-written Note.