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Sheltering Psychiatric Patients from the DeShaney Storm: A Proposed Analysis for Determining Affirmative Duties to Voluntary Patients

Claire Marie Hagan

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Sheltering Psychiatric Patients from the *DeShaney* Storm: A Proposed Analysis for Determining Affirmative Duties to Voluntary Patients[†]

Claire Marie Hagan*

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I. Introduction

The government owes us nothing. That is, the Constitution does not require the government to protect us or to provide services.¹ Instead, the Constitution restricts the government from

1. See SOTIRIOS BARBER, WELFARE AND THE CONSTITUTION 23 (2003)

acting.² For example, citizens enjoy the sense of security provided by their local police force, but the police are not constitutionally obligated to respond to every emergency call.³ As a corollary to this “no-duty” rule, state actors generally cannot be liable for inaction.⁴ Plaintiffs who sue the state on an affirmative-duty based claim face a formidable challenge, and yet plaintiffs frequently assert the claims.⁵

The no-duty rule is not without exception. In *Youngberg v. Romeo*,⁶ the Supreme Court ruled that states⁷ owe involuntarily committed state-hospital patients affirmative duties of care, protection, and rehabilitation.⁸ In the 1970s and 1980s, the Court also recognized affirmative duties for prisoners,⁹ for pre-trial detainees,¹⁰ and for arrestees.¹¹ But in *DeShaney v. Winnebago County Department of Social Services*,¹² the Supreme Court

(explaining that the negative-liberties model of the Constitution provides no basis for substantive benefits).

2. *Id.*

3. See *Town of Castle Rock v. Gonzales*, 545 U.S. 748, 760–61 (2005) (stating that states have discretion in exercising their police functions).

4. See *DeShaney v. Winnebago Cnty. Dep’t of Soc. Servs.*, 489 U.S. 189, 196–97 (1989) (“[T]he State cannot be held liable under the [Due Process] Clause for injuries that could have been averted had it chosen to provide them.”).

5. See 1 MARTIN A. SCHWARTZ, SECTION 1983 LITIGATION: CLAIMS AND DEFENSES § 3.09[D] (4th ed. 2012) (“[Section] 1983 claimants continue to file large numbers of due process duty to protect claims.”).

6. See *Youngberg v. Romeo*, 457 U.S. 307, 316–17 (1982) (ruling that states owe affirmative duties under substantive due process to involuntarily committed individuals).

7. This Note uses the term “state” to include state and local entities and their agents.

8. *Youngberg*, 457 U.S. at 316–17.

9. See *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (establishing that, under the Eighth Amendment, states owe affirmative duties to provide medical care to prisoners).

10. See *Bell v. Wolfish*, 441 U.S. 520, 545 (1979) (establishing states’ affirmative duty to provide safe conditions to pretrial detainees).

11. See *City of Revere v. Mass. Gen. Hosp.*, 463 U.S. 239, 244 (1983) (establishing states’ affirmative duty to provide emergency medical care to persons under arrest).

12. See *DeShaney v. Winnebago Cnty. Dep’t of Soc. Servs.*, 489 U.S. 189, 191 (1989) (holding that the state’s failure to protect an individual from private harm did not violate the Due Process Clause).

sharply cabined liability premised on affirmative-duty theories and fortified the general no-duty rule.¹³ Nonetheless, *DeShaney* reiterated *Youngberg*'s rule that involuntary patients enjoy affirmative rights.¹⁴ And circuit courts generally interpret *DeShaney* as creating a rule that affirmative duties arise in three discrete scenarios: (1) formal custody; (2) functional custody; and (3) state-created danger.¹⁵

State hospitals present a unique context for analyzing affirmative duties. Unlike criminal custodial settings, state laws set forth procedures for people to either voluntarily enter state hospitals or to be involuntarily committed.¹⁶ The "voluntary" and "involuntary" labels seem, at first blush, to describe a particular patient's relationship to the state: Involuntary patients are held against their will, and voluntary patients fully consent to hospitalization. The "voluntary" label often provides a faulty description, however, because state-hospital patients may lack competency to give informed consent, and coercive forces may taint their consent.¹⁷

This Note focuses on affirmative duties to voluntary state-hospital patients.¹⁸ If the state involuntarily commits a patient, formally taking custody, then the state has an affirmative duty to

13. See PETER IRONS, BRENNAN VS. REHNQUIST 107 (1994) ("The Court went out of its way to decide the *DeShaney* case. . . . Rehnquist's majority opinion in the case suggests that he wanted to send a message to federal judges.").

14. See *id.* at 199 (discussing established affirmative-duty contexts).

15. See *infra* Part II.C.1 (discussing the functional custody exception); *infra* Part II.C.2 (discussing the state-created danger exception). For clarity, in this Note, "formal custody" refers to incarceration, involuntary commitment, pre-trial detention, and arrest. "Functional custody" refers to analogous situations in which the state, through affirmative acts, creates a custodial relationship. "State-created danger" refers to situations in which the state acts either to create a danger or to render an individual more vulnerable to a danger.

16. See *infra* Part III.A (reviewing commitment laws).

17. See *infra* Part V (raising concerns with the voluntary distinction).

18. This Note uses the terms "mental health patient" and "state-hospital patient" to refer to individuals receiving inpatient treatment in state-operated psychiatric facilities, either voluntarily or involuntarily. Patients in private facilities are outside this Note's scope. Private facilities and employees generally are not state actors, and therefore are not subject to § 1983. See *Civil Action for Deprivation of Rights*, 42 U.S.C. § 1983 (2006) (imposing liability against state actors).

protect and care for that person.¹⁹ But what about voluntary patients? Circuits are split on this question.²⁰ Does the state owe different obligations to patients based simply on a formal status—voluntary or involuntary?²¹ What if state law allows a facility to hold a voluntary patient for seventy-two hours after the patient decides he wants to leave?²² What if a voluntary patient is so psychiatrically ill that state law forbids discharge?²³ What if the hospital knows that a patient is likely to harm another patient?²⁴

Courts disagree on how to answer these questions.²⁵ Circuits generally take one of two approaches: (1) a strict status-based test, using an individual's formal "voluntary" or "involuntary" status to determine if the state owes affirmative duties,²⁶ or (2) a fact-intensive inquiry of whether the individual was truly a voluntary patient when the harm occurred.²⁷ Both analyses, however, emphasize the individual's commitment status—voluntary or involuntary—as the chief element.²⁸

Should courts employ the voluntary/involuntary distinction as the engine driving the analytic train? This Note argues: No. First, the distinction may amount to an artificial signifier. Affirmative duty analysis seeks to understand the relationship

19. See *infra* notes 67–71 and accompanying text (discussing *Youngberg*).

20. See *infra* Part IV (reviewing the circuit split).

21. See *infra* Part IV.A.2 (discussing the First Circuit's decision in *Monahan v. Dorchester Counseling Ctr.*, 961 F.2d 987 (1st Cir. 1992)).

22. See *infra* Part IV.B.3 (discussing the Third Circuit's decision in *Torisky v. Schweiker*, 446 F.3d 438 (3d Cir. 2006)).

23. See *infra* Part IV.B.2 (discussing the Eighth Circuit's decisions in *Kennedy v. Schafer*, 71 F.3d 292 (8th Cir. 1996), and *Shelton v. Ark. Dep't Human Servs.*, 677 F.3d 837 (8th Cir. 2012)).

24. See *infra* Part IV.A.3 (discussing the Fifth Circuit's decision in *Walton v. Alexander*, 44 F.3d 1297 (5th Cir. 1995) (en banc)).

25. See *infra* Part IV (analyzing the different approaches circuit courts take in analyzing affirmative duties to state-hospital patients).

26. See *infra* Part IV.A (reviewing cases that adopt a status-based analysis).

27. See *infra* Part IV.B (discussing cases that adopt a fact-based analysis).

28. See *infra* notes 234–41, 210–11, 257–58, 280, 303–06, 340–41 and accompanying text (discussing the circuit courts' focus on the voluntary distinction).

and course of dealings between the petitioner and the state.²⁹ While the labels “voluntary” and “involuntary” superficially signal whether a patient’s admission is a product of consent or of confinement, these labels can be misleading.³⁰ Second, the voluntary distinction loses sight of alternative bases for affirmative rights. When courts focus on whether a state-hospital patient is voluntary, either by status or de facto, the court may overlook or neglect to explore fully the functional custody and state-created danger exceptions.³¹

This Note puts forth an alternative analytic structure for deciding whether state-hospital patients can establish that the state owed affirmative *Youngberg* duties.³² Beginning with the presumption that the state owes no affirmative duty,³³ the court next considers each *DeShaney* exception in turn. First, if an individual is committed involuntarily, then *Youngberg* duties exist based on formal custody. Second, if an individual is a voluntary patient, then *Youngberg* duties exist if the state exercises functional custody by restricting the person’s liberty. Third, if an individual is a voluntary patient, then *Youngberg* duties exist if the state creates or increases a danger threatening the individual.

Part I of this Note introduces the issues to be addressed. Part II reviews substantive due process and its general role in restricting government action. Part II then analyzes *Youngberg* and *DeShaney* before briefly reviewing the current state of affirmative duty law, including both the functional custody and the state-created danger doctrines. Part III focuses on mental health law, providing a background on the laws governing

29. See *Daniels v. Williams*, 474 U.S. 327, 332 (1986) (explaining that the Fourteenth Amendment governs the relationship between individuals and state governments).

30. See *infra* Part V.A (examining competency and coercion in voluntary admissions).

31. See *infra* notes 266, 339–42 and accompanying text (discussing the circuits’ focus on voluntariness, rather than on functional custody or state-created danger); *infra* notes 214–20 and accompanying text (discussing Judge Suhreinrich’s concurrence in *Higgs*, which argued that the majority should have considered functional custody and state-created danger).

32. *Infra* Part VI.

33. See *infra* Part VI.A (containing this Note’s recommended analysis).

voluntary and involuntary admission and on the state hospital context in light of recent historical trends. Part IV reviews the circuit split over whether voluntary state-hospital patients are owed affirmative duties. Part V raises concerns about circuits' focus on the voluntary/involuntary distinction. This Note concludes in Part VI by proposing an analysis for approaching affirmative duties in the state hospital context, arguing that this approach gives appropriate weight to voluntary/involuntary issues, retains doctrinal integrity, and will not overburden states.

II. Substantive Due Process and Affirmative Duties

The Fourteenth Amendment's Due Process Clause protects individuals from unreasonable or oppressive government action.³⁴ State actors violate an individual's substantive due process rights if they act so unreasonably or so oppressively that no amount of procedural protections could justify their action.³⁵ The scope of these substantive rights, however, is quite limited.³⁶ Constitutional law does not remedy every state actor's wrong.³⁷

Due process of law originated in English law as a legal maxim meant to restrain the sovereign.³⁸ At common law, the substantive prong protected property and contract rights.³⁹ American jurisprudence continued recognizing due process as a "significant constitutional limitation[]" on executive and

34. See *Daniels*, 474 U.S. at 331 (explaining that the Due Process Clause provides procedural and substantive protections against government action depriving individuals of life, liberty, or property in an arbitrary or oppressive manner). This Note focuses only on the substantive prong of due process.

35. *Id.*

36. *Id.*

37. See *id.* at 332 ("[The Constitution] does not purport to supplant traditional tort law in laying down rules of conduct to regulate liability for injuries that attend living together in society.").

38. See JOHN V. ORTH, *DUE PROCESS OF LAW: A BRIEF HISTORY* 7, 9 (2003) (discussing the Magna Carta's guarantee that "the law of the land" safeguards individual rights).

39. See *id.* at 98–102 (summarizing the common law roots of due process and the doctrine's evolution in American jurisprudence).

legislative power.⁴⁰ Over time, the doctrine evolved, with substantive due process now protecting individual interests “relating to marriage, family, procreation, and the right to bodily integrity.”⁴¹ The Court has long held that individuals possess a fundamental right to personal autonomy,⁴² including in a medical setting.⁴³

Patients who suffer some injury while in a state hospital may claim that the state violated their substantive due process rights.⁴⁴ Due process rights may be vindicated via claims brought under 42 U.S.C. § 1983.⁴⁵ And in the last few decades, § 1983 has “emerged as a potent weapon for state hospital patients.”⁴⁶ These constitutional claims are popular for mental health advocates seeking “system-wide changes,” because § 1983 actions offer injunctive relief and legal fees in addition to compensatory damages.⁴⁷

40. *Id.* at 9.

41. *Albright v. Oliver*, 510 U.S. 266, 272 (1994) (plurality opinion).

42. *See Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891) (“No right is held more sacred, or is more carefully guarded . . . than the right of every individual to the possession and control of his own person, free from all restraint or interference of others.”).

43. *See Schloendorff v. Soc’y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (“Every human being of adult years and sound mind has a right to determine what shall be done with his own body.”). The Supreme Court has adopted Judge Cardozo’s articulation in *Schloendorff* of the individual’s right to control his body from unwanted medical intervention. *Cruzan v. Mo. Dep’t of Health*, 497 U.S. 261, 269 (1990).

44. *See* U.S. CONST. amend. XIV, § 1 (“[N]or shall any State deprive any person of life, liberty, or property, without due process of law.”).

45. *See* Civil Action for Deprivation of Rights, 42 U.S.C. § 1983 (2012)

Every person who, under color of any statute, ordinance, regulation, custom, or usage . . . subjects, or causes to be subjected, any citizen of the United States . . . to the deprivation of any rights . . . secured by the Constitution and laws, shall be liable to the party injured.

46. *See* PAUL S. APPELBAUM & THOMAS G. GUTHEIL, *CLINICAL HANDBOOK OF PSYCHIATRY & THE LAW* 137 (4th ed. 2007) (discussing how mental health advocates began using civil rights actions under § 1983 in the late twentieth century to achieve social reform).

47. *See id.* at 138 (explaining why the remedies available pursuant to a § 1983 claim may be more attractive than state law tort remedies when legal advocates hope to effect broad change in state hospitals).

This Part first reviews the doctrine of substantive due process. Generally, this doctrine restricts, rather than mandates, government action.⁴⁸ Then, this Part reviews the two Supreme Court cases governing when a state owes affirmative duties to state-hospital patients: *Youngberg* and *DeShaney*.⁴⁹ Finally, this Part summarizes the affirmative-duty rules that circuit courts have developed after *DeShaney*.⁵⁰

A. Substantive Due Process: A Charter of Negative Duties

Substantive due process foists negative duties on the government, curtailing its power.⁵¹ Judge Posner, writing for the Seventh Circuit, articulated the Fourteenth Amendment's scope in a case involving a dangerous, mentally ill person who—subsequent to being released by the state—murdered the plaintiff's decedent:

There is a constitutional right not to be murdered by a state officer, for the state violates the Fourteenth Amendment when its officer, acting under color of state law, deprives a person of life without due process of law. But there is no constitutional right to be protected by the state against being murdered by criminals or madmen. It is monstrous if the state fails to protect its residents against such predators but it does not violate the due process clause of the Fourteenth Amendment or, we suppose, any other provision of the Constitution. The Constitution is a charter of negative liberties; it tells the state to let people alone; it does not require the federal government or the state to provide services, even so elementary a service as maintaining law and order.⁵²

The Supreme Court consistently affirms this characterization of the Fourteenth Amendment as “a charter of negative liberties.”⁵³

48. See *infra* Part II.A (explaining the general no-duty rule).

49. See *infra* Part II.B (examining *Youngberg* and *DeShaney*).

50. See *infra* Part II.C (discussing post-*DeShaney* developments).

51. See *DeShaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 195 (1989) (“The [Substantive Due Process] Clause is phrased as a limitation on the State's power to act . . .”).

52. *Bowers v. DeVito*, 686 F.2d 616, 618 (7th Cir. 1982) (citations omitted).

53. See *Collins v. City of Harker Heights*, 503 U.S. 115, 126 (1992)

B. Affirmative Duty Exceptions: Youngberg and DeShaney

The general rule that the Due Process Clause imposes negative duties is not absolute. In discrete contexts, the Clause imposes affirmative duties, calling on the state to proactively serve or protect.⁵⁴

Circuit courts have labored to define the scope of affirmative duties for several decades. In *Martinez v. California*,⁵⁵ Justice Stevens suggested in dicta that a state might owe an affirmative duty of protection if the state (1) becomes aware of a special danger threatening a specific individual and (2) indicates a willingness to protect that person.⁵⁶ Many circuits interpreted this language to create a “special-relationship” doctrine, whereby the government undertakes an obligation to protect persons with whom it shares a special relationship.⁵⁷ These circuits began

(“Neither the text nor the history of the Due Process Clause supports petitioner’s claim that the governmental employer’s duty to provide its employees with a safe working environment is a substantive component of the Due Process Clause.”); *Davidson v. Cannon*, 474 U.S. 344, 348 (1986) (“The guarantee of due process has never been understood to mean that the State must guarantee due care on the part of its officials.”).

54. See *DeShaney*, 489 U.S. at 198 (“It is true that in certain limited circumstances the Constitution imposes upon the State affirmative duties of care and protection with respect to particular individuals.”).

55. See *Martinez v. California*, 444 U.S. 277, 284 (1980) (holding that the state was not liable for a murder committed by a parolee five months after the state released him).

56. See *id.* at 285

[T]he parole board was not aware that appellants’ decedent, as distinguished from the public at large, faced any special danger. We need not and do not decide that a parole officer could never be deemed to “deprive” someone of life by action taken in connection with the release of a prisoner on parole.

57. See, e.g., *Balistreri v. Pacifica Police Dep’t*, 855 F.2d 1421, 1425–26 (9th Cir. 1988) (ruling that the plaintiff’s allegations that the state owed an affirmative duty of police protection after the state issued a restraining order and received notice of plaintiff’s danger was sufficient to state a claim under the special-relationship doctrine); *Estate of Bailey v. Cnty. of York*, 768 F.2d 503, 510–11 (3d Cir. 1985) (vacating and remanding the district court’s dismissal of a § 1983 claim and ruling that plaintiff might be able to prove the state violated an affirmative duty arising under the special-relationship doctrine); *Jones v. Phyfer*, 761 F.2d 642, 644–45 (11th Cir. 1985) (“What is required in a 42 U.S.C. § 1983 action is the establishment of a special relationship between the victim and the criminal or between the victim and the state, or some showing that the

finding affirmative duties grounded in substantive due process following *Martinez*.

In the context of mental health patients, two Supreme Court cases shape the legal doctrine. First, in *Youngberg*,⁵⁸ the Court held that the government takes on affirmative duties when it involuntarily confines a person to a mental health facility.⁵⁹ Second, in *DeShaney*,⁶⁰ the Court hemmed in the scope of affirmative duties.⁶¹

victim, as distinguished from the public at large, faced a special danger.”); *Jensen v. Conrad*, 747 F.2d 185, 190–94 & n.11 (4th Cir. 1984) (dictum) (examining circuit precedent and concluding that affirmative duties may arise out of special relationships, particularly if factors such as legal custody, expressed desire by state to help, and state’s knowledge of claimant’s danger are present), *cert. denied*, 470 U.S. 1052 (1985); *Fox v. Curtis*, 712 F.2d 84, 88 (4th Cir. 1983) (stating that “a right and corollary duty *may* arise out of special custodial or other relationships created or assumed by the state in respect of particular persons”). *But see, e.g.*, *Harpoole v. Ark. Dep’t of Human Servs.*, 820 F.2d 923, 926–27 (8th Cir. 1987) (analyzing and rejecting the special-relationship doctrine, and criticizing its reliance on Supreme Court dicta rather than statutory text or constitutional principles); *Wideman v. Shallowford Cmty. Hosp.*, 826 F.2d 1030, 1035–36 (11th Cir. 1987) (ruling that constitutional affirmative duties arise only when the state creates or increases a danger through its “exercise of coercion, dominion, or restraint”); *Estate of Gilmore v. Buckley*, 787 F.2d 714, 720–22 (1st Cir. 1986) (noting that the Supreme Court’s “vague hints” left “the door slightly ajar” for special-relationship claims, but ruling that “the state must be more directly implicated” in causing the harm than merely knowing of a special danger), *cert. denied*, 479 U.S. 882 (1986).

58. *See Youngberg v. Romeo*, 457 U.S. 307, 324 (1982) (ruling that an individual who has been involuntarily committed to a psychiatric hospital “enjoys constitutionally protected interests in conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests”).

59. *Id.*

60. *See DeShaney v. Winnebago Cnty. Dep’t of Soc. Servs.*, 489 U.S. 189, 191 (1989) (holding that the state’s failure to protect an individual from private harm did not violate the Due Process Clause).

61. *See id.* at 196 (“[O]ur cases have recognized that the Due Process Clauses generally confer no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests of which the government itself may not deprive the individual.”).

1. *Youngberg v. Romeo*

In 1982, the Supreme Court first considered whether an involuntarily confined mental health patient possesses liberty interests under substantive due process in *Youngberg v. Romeo*.⁶² *Youngberg* involved a “profoundly retarded” thirty-three-year-old man who was civilly committed to Pennhurst, a state psychiatric facility, because he posed an imminent danger to himself and others.⁶³ At Pennhurst, hospital staff proposed a treatment plan designed to reduce Mr. Romeo’s aggressive and violent behaviors, but never implemented it.⁶⁴ Mr. Romeo repeatedly suffered injuries, some of which were self-inflicted, during the hospitalization.⁶⁵ Mr. Romeo’s mother filed suit against the hospital’s directors and supervisors, alleging in part that the defendants violated Mr. Romeo’s Fourteenth Amendment Due Process rights.⁶⁶

The Supreme Court ruled that the State had violated Mr. Romeo’s substantive due process rights by not fulfilling its affirmative obligation to protect and care for him.⁶⁷ Justice Powell, writing for the majority, analogized involuntary state hospitalization to incarceration.⁶⁸ Just as the state owes affirmative duties to prisoners in public prisons, it also owes duties to involuntary patients in public hospitals.⁶⁹ The hospital must provide food, shelter, clothing, and medical care to all

62. *Youngberg*, 457 U.S. at 314.

63. *Id.* at 309–10.

64. *Id.* at 310–11.

65. *See id.* at 310 (stating that petitioner’s complaint alleged that Mr. Romeo was injured “on at least sixty-three occasions”).

66. *Id.*

67. *See id.* at 324 (“Respondent thus enjoys constitutionally protected interests in conditions of reasonable care and safety, reasonably nonrestrictive confinement conditions, and such training as may be required by these interests.”).

68. *Id.* at 315.

69. *See id.* at 315–16 (“If it is cruel and unusual punishment to hold convicted criminals in unsafe conditions, it must be unconstitutional to confine the involuntarily committed—who may not be punished at all—in unsafe conditions.”).

patients.⁷⁰ But Mr. Romeo's rights included more than these basic services. The Court ruled that states owe involuntarily committed individuals certain rights (*Youngberg* rights): (1) the right to reasonable care and safety; (2) the right to reasonably nonrestrictive conditions; and (3) the right to any training or rehabilitation associated with these interests.⁷¹

The decision does not address whether *Youngberg* rights extend to voluntary patients. Some lower courts interpreted Justice Powell's opinion as applying to all mental health patients, irrespective of the method of admission—voluntary or involuntary.⁷² Additionally, some circuit courts continued finding affirmative duties based on *Martinez* and the special-relationship doctrine.⁷³

In 1989, the Supreme Court revisited its affirmative duty rulings in *DeShaney*, a case set outside of a psychiatric institution, but nonetheless broadly addressing the scope and nature of substantive due process protections.⁷⁴

2. *DeShaney v. Winnebago County Department of Social Services*

In *DeShaney*, the Supreme Court considered whether the Substantive Due Process Clause requires states to protect

70. See *id.* at 315, 324 (noting in dicta that the State conceded that it owes these duties to all state-hospital patients).

71. See *id.* at 314–25 (finding each of these liberty interests). The Court further determined that a “professional judgment” standard should apply to determine whether the state violated its duties to protect or care for a patient. See *id.* at 321–22 (reasoning that deferring to the hospital clinicians' judgment is appropriate because it allows hospitals to concentrate on treating patients according to their individual needs without imposing an onerous blanket rule).

72. See *Savidge v. Fincannon*, 836 F.2d 898, 907 n.44 (5th Cir. 1988) (rejecting the argument that *Youngberg* applies only when an individual has been confined through formal proceedings); *Ass'n for Retarded Citizens of N.D. v. Olson*, 561 F. Supp. 473, 485 (D.N.D. 1982) (“[I]f the plaintiffs had voluntarily consented to their admission to the Grafton state school, it would not follow that all their rights to liberty under the due process clause were waived.”), *aff'd and remanded*, 713 F.2d 1384 (8th Cir. 1983).

73. See *supra* note 57 (listing pre-*DeShaney* circuit cases on special relationships).

74. See *infra* Part II.B.2 (examining the *DeShaney* ruling).

individuals from private—rather than state-inflicted—harm.⁷⁵ *DeShaney* is not about mental health patients. Joshua DeShaney was a four-year-old boy who became involved with Wisconsin’s Department of Social Services (DSS) in January 1983 because of his father’s abuse.⁷⁶ During 1983, Joshua was hospitalized three times for injuries; hospital staff suspected child abuse each time and contacted DSS.⁷⁷ DSS placed Joshua under the hospital’s temporary custody for three days after the first report, but returned Joshua to his father’s home three days later, and began sending a social worker out to visit the home monthly.⁷⁸ Over a period of a little more than a year, Joshua kept showing up the emergency room, injured; the hospital kept reporting the injuries to DSS; and DSS kept sending the social worker—and nothing more.⁷⁹ The social worker documented “suspicious injuries on Joshua’s head” and “continuing suspicions” that Joshua was being physically abused.⁸⁰ Despite these reports, DSS took no further action.⁸¹ In March 1984, Joshua went into a life-threatening coma.⁸² Emergency surgery revealed brain damage resulting from repeated head injuries over a long period.⁸³ Now “profoundly retarded,” he would likely spend the rest of his life in an institution.⁸⁴ Joshua’s mother sued DSS on his behalf, alleging that DSS knew of or should have reasonably known about the abuse, and so the State violated Joshua’s due process rights by failing to protect him.⁸⁵

75. See *DeShaney v. Winnebago Cnty. Dep’t of Soc. Servs.*, 489 U.S. 189, 194 (1989) (characterizing the issue presented as “when, if ever, the failure of a state or local governmental entity or its agents to provide an individual with adequate protective services constitutes a violation of the individual’s due process rights”).

76. *Id.* at 192–93.

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.*

81. *Id.*

82. *Id.* at 193.

83. *Id.*

84. *Id.*

85. *Id.* at 193–94.

The Supreme Court disagreed. Chief Justice Rehnquist, writing for the majority, analyzed the scope of substantive due process and the nature of its protections. The majority began its analysis with the principle that the Due Process Clause functions as a limitation on the government.⁸⁶ The Clause restricts the government—it does not empower the government by requiring states to protect society or provide services.⁸⁷ From this premise, the majority reasoned that a state cannot be liable for private violence because states have no duty to protect against this violence.⁸⁸ *Youngberg*, according to the majority, “stand[s] for the proposition that when [a] State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being.”⁸⁹

The Court also expressly rejected the argument that affirmative duties might derive from a special relationship.⁹⁰ The special-relationship doctrine implied that affirmative duties arise from the state’s knowledge of danger and its indicated willingness to help.⁹¹ Chief Justice Rehnquist pointed out that the doctrine’s analysis misconstrues the nature and purpose of affirmative duties, which are meant to protect individuals from harms caused

86. *See id.* at 194–96 (reviewing the Clause’s text, history, and supporting doctrine).

87. *See id.* at 196 (“The Due Process Clauses generally confer no affirmative right to governmental aid.”). Some scholars criticize Chief Justice Rehnquist’s interpretation of the Due Process Clause, arguing that it “fundamentally distorts the meaning . . . by abstracting the language from its historical context.” Steven J. Heyman, *The First Duty of Government: Protection, Liberty and the Fourteenth Amendment*, 41 DUKE L.J. 507, 561 (2001). In his Article, Professor Heyman analyzes the Fourteenth Amendment’s origins from English law, as well as the congressional debates and framers’ intentions in adopting the Amendment. *Id.* He concludes that the view that the Due Process Clause provides only negative duties is “indefensible, and that the history of the Fourteenth Amendment in no way forecloses recognition of a constitutional right to protection.” *Id.* at 512.

88. *DeShaney*, 489 U.S. at 196–97.

89. *Id.* at 199–200. Justice Brennan criticized this characterization of *Youngberg* in his dissent. *Infra* notes 103–04 and accompanying text.

90. *See id.* at 197–98 (discussing the special-relationship argument advanced here by petitioners and accepted in several circuit courts after *Martinez*, but ultimately rejecting the argument).

91. *Id.* at 197 n.4.

by affirmative state acts that render people unable to act on their own behalf.⁹² Without affirmative state action, duties will not arise.⁹³

Justice Brennan, joined by Justices Marshall and Blackmun, dissented and criticized the majority's analytic posture.⁹⁴ Justice Brennan did not disagree that, as a general principle, the Due Process Clause imposes no obligation on the government to provide services.⁹⁵ But the majority's "initial fixation" with this principle led it astray.⁹⁶ Approaching affirmative-duty claims with "suspicion," the majority framed the case as one about *inaction*: the state's failure to protect Joshua.⁹⁷ Any actions that the state did take became tangentially important.⁹⁸ To the majority, the question was whether a state should be liable for *inaction*. The majority viewed the facts through a skewed lens.⁹⁹ Focusing in on what did *not* happen—the ways the state did *not* exercise custody or increase Joshua's vulnerability, "foreshadow[ed]—perhaps even preordain[ed]" the conclusion.¹⁰⁰ Justice Brennan argued that a proper analysis should begin differently and ask what actions the state *did* take.¹⁰¹

Justice Brennan also took issue with the majority's characterization of *Youngberg*—that the state owed affirmative duties because it confined Mr. Romeo's liberty through civil commitment.¹⁰² Justice Brennan asserted that Mr. Romeo's constitutional right did not spring from the government's prior

92. *Id.* at 200.

93. *Id.*

94. *Id.* at 203–12 (Brennan, J., dissenting).

95. *See id.* at 203 (stating that the Court's precedent supports this principle).

96. *See id.* at 205 (stating that the majority's preoccupation with the negative rights principle leaves the majority "unable to appreciate" Court precedent related to when affirmative rights arise).

97. *Id.* at 204.

98. *Id.*

99. *See id.* (arguing that the majority's baseline perspective of no positive rights brings about "a concomitant suspicion of any claim that seems to depend on such rights").

100. *Id.*

101. *Id.* at 205.

102. *Id.* at 206.

act of committing him.¹⁰³ The affirmative duty arose because the state “separated him from other sources of aid,” obliging the state to provide substitute aid.¹⁰⁴ Mr. Romeo was unable to care for himself because he was mentally retarded, not because he was confined.¹⁰⁵

In a separate dissent, Justice Blackmun highlighted the case’s tragic facts, “displaying emotion rarely seen in Supreme Court opinions.”¹⁰⁶ He argued that the majority’s “sterile formalism” in distinguishing between action and inaction was inappropriate and marked “a sad commentary on American life, and constitutional principles.”¹⁰⁷ DSS knew that Joshua was in danger, and DSS *chose* “inaction.”¹⁰⁸ The majority, he asserted, misread “the broad and stirring Clauses of the Fourteenth Amendment,” which were designed to prevent such a rigidly formalistic interpretation of the law.¹⁰⁹ By adopting this formalistic distinction between action and inaction, Justice Blackmun alleged, the majority opinion recalled “the antebellum judges who denied relief to fugitive slaves.”¹¹⁰

Despite passionate criticisms in the dissents and from legal scholars,¹¹¹ *DeShaney* remains good law.¹¹² The Substantive Due

103. See *id.* (“This restatement of *Youngberg’s* holding should come as a surprise.”).

104. *Id.*

105. *Id.*

106. See ERWIN CHERMERINSKY, THE CONSERVATIVE ASSAULT ON THE CONSTITUTION 184 (2010) (summarizing Justice Blackmun’s dissent).

107. *DeShaney v. Winnebago Cnty. Dep’t of Soc. Servs.*, 489 U.S. 189, 212–13 (1989) (Blackmun, J., dissenting).

108. *Id.* at 212.

109. *Id.*

110. *Id.*

111. See, e.g., CHERMERINSKY, *supra* note 106, at 182 (arguing that *DeShaney* represents a “particularly troubling” example of how a “conservative attack” on the Constitution in recent decades has caused the Supreme Court to limit constitutional liberties and protections); Laurence H. Tribe, *The Curvature of Constitutional Space: What Lawyers Can Learn from Modern Physics*, 103 HARV. L. REV. 1, 10 (1989) (criticizing the majority’s analysis because its “stilted, pre-modern paradigm” fails to understand how Wisconsin “may itself have played a major role in shaping the world it observes”).

112. See *infra* notes 118–19 (stating that *DeShaney* remains the Supreme Court’s preeminent ruling on affirmative duties under substantive due process).

Process Clause does not generally require states to affirmatively protect individuals, and so a state is not liable if an individual becomes injured after the state fails to protect him.¹¹³ *DeShaney*'s tone strongly suggests that it hoped to firmly limit the scope of affirmative duties.¹¹⁴ The Chief Justice, however, identified several contexts that give rise to affirmative duties on the state: (1) in previously enumerated contexts involving formal custody—incarceration, civil commitment, pre-trial detention, and police custody;¹¹⁵ (2) when a state takes an individual into functional custody through an affirmative action, restricting that person's ability to protect himself;¹¹⁶ and (3) when a state creates a danger or causes an individual to be more vulnerable to a danger.¹¹⁷

C. Affirmative Duties After *DeShaney*

DeShaney remains the Supreme Court's authoritative ruling on affirmative duties under the Substantive Due Process Clause.¹¹⁸ The Court has subsequently affirmed *DeShaney*'s

113. *DeShaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 196–97 (1989).

114. *See id.* at 202–03 (remarking that “natural sympathy” pushes judges and lawyers to seek compensation for Joshua, but cautioning that the state actors “should not have [liability] thrust upon them by this Court's expansion of the Due Process Clause”).

115. *Id.* at 198–99. *DeShaney* noted that some circuit court precedent also includes foster children in this list, but the Court declined to rule on this issue. *Id.* at 201 n.9. Most circuits addressing this issue since *DeShaney* have ruled that states owe affirmative duties to children placed in foster homes. *See* MARTIN A. SCHWARTZ & KATHRYN R. URBONYA, SECTION 1983 LITIGATION 40–41 & n.213 (Fed. Judicial Ctr., 2d ed. 2008) (collecting relevant circuit cases).

116. *See DeShaney*, 489 U.S. at 200 (“[I]t 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.” (emphasis added)).

117. *See id.* at 201 (“While the State may have been aware of the dangers that Joshua faced in the free world, it *played no part in their creation*, nor did it *do anything to render him any more vulnerable to them.*” (emphasis added)).

118. *See* Erwin Chemerinsky, *Government Duty to Protect: Post-DeShaney Developments*, 19 TOURO L. REV. 679, 683 (2003) (“*DeShaney* is the touchstone for all subsequent discussions about the affirmative duty to provide protection under due process.”).

holding,¹¹⁹ expressing its “reluctan[ce] to expand the concept of substantive due process because guideposts for responsible decisionmaking in this unchartered area are scarce and open-ended.”¹²⁰ Expanding due process through judicial decisions creates the risk that the judiciary’s policy preferences will define the scope of protected liberties.¹²¹

Despite the Court’s self-imposed restraint, it has not scaled back established affirmative duties. Since *DeShaney*, the Supreme Court has reiterated that affirmative duties exist in the enumerated and recognized contexts of formal confinement—prisons, pre-trial detainees, arrestees, and “persons in mental institutions.”¹²² The functional custody and state-created danger exceptions identified in *DeShaney* give plaintiffs alternative avenues for holding the government constitutionally liable for a private harm.¹²³

In the years since *DeShaney* came down, circuit courts have fashioned different variations on the functional custody and state-created danger exceptions.

119. See *Collins v. City of Harker Heights*, 503 U.S. 115, 126–27 (1992) (ruling that the Due Process Clause does not impose an affirmative duty on municipalities to provide minimal safety levels for employees); *Town of Castle Rock v. Gonzales*, 545 U.S. 748, 773 (2005) (Stevens, J., dissenting) (calling it “perfectly clear” that the Constitution imposes no general obligation on the state to provide police protection).

120. *Collins*, 503 U.S. at 125; see also *Washington v. Glucksberg*, 521 U.S. 702, 720 (1997) (asserting the importance of judicial restraint, because “[b]y extending constitutional protection to an asserted right or liberty interest, we, to a great extent, place the matter outside the arena of public debate and legislative action”).

121. See *Moore v. City of E. Cleveland*, 431 U.S. 494, 502 (1989) (plurality opinion) (calling substantive due process a “treacherous field for this Court” and arguing that “history counsels caution and restraint” in identifying new substantive liberty interests).

122. *Collins*, 503 U.S. at 127.

123. See Erwin Chemerinsky, *The State-Created Danger Doctrine*, 23 *TOURO L. REV.* 1, 1 (2007) (reviewing the theories available for establishing that the government owes an individual an affirmative duty after *DeShaney*).

1. *The Functional Custody Exception*

DeShaney suggests that a state acquires an affirmative duty to care for and protect an individual when the state acts to restrain that person's liberty.¹²⁴ Most circuits have subsequently interpreted this language in *DeShaney* as establishing affirmative duties when a state takes "functional custody"¹²⁵ over an individual.¹²⁶

Circuits generally apply the functional custody exception and find an affirmative duty to protect when the state "affirmatively places the individual in a position of danger [that] the individual would not have otherwise faced."¹²⁷ Some circuits explicitly require an element of involuntariness: the state must have taken custody over the individual against his will.¹²⁸ The level of control

124. See *DeShaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 200 (1989) ("[I]t 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 [duty]." (emphasis added)).

125. Many courts and scholars refer to the situation in which a state restricts an individual's liberty through an affirmative act as a "special relationship." See, e.g., *Patel v. Kent Sch. Dist.*, 648 F.3d 965, 971 (9th Cir. 2011) (stating that *DeShaney* creates a "special relationship exception" when a state restricts a person's liberty such that the person cannot protect himself). To avoid confusion with the special-relationship doctrine that arose under *Martinez*—which *DeShaney* explicitly rejects—this Note uses the term "functional custody" to denote situations in which a state's action restricts a person's liberty and thereby creates a constitutional obligation for the state to protect that person. See *supra* notes 57, 90–92 and accompanying text (reviewing the special-relationship exception after *Martinez* and *DeShaney*'s subsequent rejection of this doctrine).

126. See SCHWARTZ & URBONYA, *supra* note 115, at 40 (discussing functional custody).

127. *Wallace v. Adkins*, 115 F.3d 427, 429 (7th Cir. 1997). See also *Armigo v. Wagon Mound Pub. Schs.*, 159 F.3d 1253, 1261 (10th Cir. 1998) ("[L]iability may attach to a state actor for the violence of a third party if the state restrained the plaintiff's personal liberty and that restraint hindered the plaintiff's freedom to act to protect himself.").

128. See *Randolph v. Cervantes*, 130 F.3d 727, 730 (5th Cir. 1997) (stating that functional custody requires that the state's action be "*involuntary or against his will*" (internal citations omitted)). See also *Petition for Writ of Certiorari* at 7–8, *Kovacic v. Villarreal*, No. 10-1235, 2011 WL 1393814, at *7–8 (Mar. 8, 2011) (requesting clarification on the "swirling, murky waters" of functional custody doctrine), *cert. denied*, 131 S. Ct. 2995 (2011).

a state exercises may also affect this analysis, as circuits sometimes hinge functional custody on whether the individual “depend[ed] completely on the state to satisfy [his] basic human needs” and the state’s action prevented other sources of care.¹²⁹

Individuals have asserted claims based on functional custody in various circumstances and found varying success. Most circuits recognize the state’s act of placing a child in foster care to be sufficient for establishing affirmative duties.¹³⁰ By contrast, state laws mandating school attendance usually fail to establish functional custody—meaning that public schools do not owe affirmative duties to students—because the attendance laws do not sufficiently restrain the child.¹³¹

129. *Maldonado v. Josey*, 975 F.2d 727, 733 (10th Cir. 1992), *cert. denied*, 507 U.S. 914 (1993).

130. *See Doe ex rel. Johnson v. S.C. Dep’t of Soc. Servs.*, 597 F.3d 163, 175 (4th Cir. 2010) (“We now hold that when a state involuntarily removes a child from her home, thereby taking the child into its custody and care, the state has taken an affirmative act to restrain the child’s liberty, triggering the [affirmative] protections of the Due Process Clause.”); *Nicini v. Morra*, 212 F.3d 798, 808 (3d Cir. 2000) (en banc) (“[W]hen [a] state places a child in state-regulated foster care, the state has entered into a special relationship with that child which imposes upon it certain affirmative duties.”); *Norfleet ex rel. Norfleet v. Ark. Dep’t of Human Servs.*, 989 F.2d 289, 293 (8th Cir. 1993) (“[A] special custodial relationship . . . was created by the state when it took [a child] from his caregiver and placed him in foster care.”); *Yvonne L. Lewis v. N.M. Dep’t of Human Servs.*, 959 F.2d 883, 892–93 (10th Cir. 1992) (finding a clearly established right for foster children to be placed in safe conditions); *K.H. ex rel. Murphy v. Morgan*, 914 F.2d 846, 853 (7th Cir. 1990) (determining that states owe affirmative duties to foster children, reasoning that “[o]nce the state assumes custody of a person, it owes him a rudimentary duty of safekeeping no matter how perilous his circumstances when he was free”); *Meador v. Cabinet for Human Res.*, 902 F.2d 474, 476 (6th Cir. 1990) (“[D]ue process extends the right to be free from the infliction of unnecessary harm to children in state-regulated foster homes.”).

131. *See, e.g., Doe ex rel. Magee v. Covington Cnty. Sch. Dist. ex rel. Keys*, 675 F.3d 849, 857 (5th Cir. 2012) (en banc) (“We reaffirm, then, decades of binding precedent: a public school does not have a *DeShaney* special relationship with its students requiring the school to ensure the students’ safety from private actors.”); *Hasenfaus v. LaJeunesse*, 175 F.3d 68, 73–74 (1st Cir. 1999) (concluding that compulsory attendance laws did not create an obligation for a school to protect a student from suicide); *Maldonado*, 975 F.2d at 732–33 (“Th[e] amount of freedom on the part of the student and the degree of parental involvement and control necessarily dictate that the state does not become the primary caretaker simply by mandating compulsory school attendance.”). But while compulsory

2. *The State-Created Danger Exception*

Most circuits also interpret *DeShaney* as acknowledging a “state-created danger exception.”¹³² This doctrine holds that a state assumes affirmative duties to protect a person when the state itself creates or increases the danger that ultimately causes the person’s harm.¹³³ This theory of liability predated *DeShaney* in some circuits. Judge Posner, who articulated the conception of the Constitution as a “charter of negative liberties,” pointed out an oft-quoted “snake pit” exception: “[I]f the state puts a man in a position of danger from private persons and then fails to protect him, it will not be heard to say that its role was merely passive; it

attendance laws may not create a uniform duty for schools to protect all students, some circuits have refused to adopt the opposite rule—that schools will *never* be constitutionally obligated to protect students from private harm. See *Hasenfaus*, 175 F.3d at 72

If [a student] had suffered a heart attack in the classroom, and the teacher knew of her peril, could the teacher merely leave her there to die without summoning help? If a six-year old child fell down an elevator shaft, could the school principal ignore the matter? Of course, school officials might be held liable in tort for such omissions, but common law liability aside, we hesitate to say for certain that substantive due process plays no role.

132. See, e.g., *Schwartz v. Booker*, No. 11-1583, 2012 WL 6604196, at *4 (10th Cir. Dec. 19, 2012); *Pena v. DePrisco*, 432 F.3d 98, 109 (1st Cir. 2005) (stating that a government actor may be liable if he creates a danger through an affirmative act); *Butera v. District of Columbia*, 235 F.3d 637, 651 (D.C. Cir. 2001) (“We . . . hold[] that, under the State endangerment concept, an individual can assert a substantive due process right to protection by the District of Columbia from third-party violence when District of Columbia officials affirmatively act to increase or create the danger that ultimately results in the individual’s harm.”). The Fifth Circuit has rejected the state-created danger exception. *Beltran v. City of El Paso*, 367 F.3d 299, 307 (5th Cir. 2004). The First Circuit has discussed and apparently recognized the doctrine, but never found resulting liability. See *Rivera v. Rhode Island*, 402 F.3d 27, 35 (1st Cir. 2005) (discussing the status of the state-created danger doctrine within the circuit). The Fourth Circuit has also discussed the doctrine, but limits affirmative duties to facts involving some degree of custody. See *Pinder v. Johnson*, 54 F.3d 1169, 1175 (4th Cir. 1995) (en banc) (“This Court has consistently read *DeShaney* to require a custodial context before any affirmative duty can arise under the Due Process Clause.”).

133. See Chemerinsky, *supra* note 123, at 3 (stating that circuits continue developing the state-created danger doctrine).

is as much an active tortfeasor as if it had thrown him into a snake pit.”¹³⁴

No uniform test for state-created danger has developed, and the Supreme Court, at this point, has declined to weigh in.¹³⁵ While circuits have crafted slightly different tests for what circumstances constitute state-created danger, their tests generally share several elements: (1) the state, through some affirmative action, created or increased a risk of harm; (2) the plaintiff—as opposed to the general public—must have been rendered more vulnerable to the harm; (3) the state must have known, or reasonably should have known, about the danger; and (4) the state’s conduct must shock the conscience.¹³⁶

Circuits continue to settle the general contours of both the state-created danger and functional custody exceptions. Context clearly plays a central role in both exceptions, and the context of voluntary psychiatric hospitalization raises unique concerns, as discussed in the next Part.

134. *Bowers v. DeVito*, 686 F.2d 616, 618 (7th Cir. 1982). Another frequently cited illustration from Judge Posner explains, “The state, having saved a man from a lynch mob, cannot then lynch him, on the ground that he will be no worse off than if he had not been saved.” *K.H. ex rel. Murphy v. Morgan*, 914 F.2d 846, 849 (7th Cir. 1990).

135. *See McClendon v. City of Columbia*, 305 F.3d 314, 324–25 (5th Cir. 2002) (reviewing different approaches taken by sister circuits).

136. *See, e.g., Bright v. Westmoreland Cnty.*, 443 F.3d 276, 281–82 (3d Cir. 2006) (laying out the circuit’s test and emphasizing that the state must have misused—rather than failed to use—its authority); *Armijo v. Wagon Mound Pub. Schs.* 159 F.3d 1253, 1262–63 (10th Cir. 1998) (“[P]laintiff must show: (1) the charged state actors created the danger or increased the plaintiff’s vulnerability; (2) the plaintiff [belonged to] a limited and specifically definable group; (3) the defendants’ conduct put the plaintiff at substantial risk of serious, immediate, and proximate harm; (4) the risk was obvious or known.”); *Kallstrom v. City of Columbus*, 136 F.3d 1055, 1067 (6th Cir. 1998) (stating that states assume affirmative duties “by substantially increasing the likelihood that a private actor would deprive [an individual] of their liberty interest in personal security”); *Mitchell v. Duval Cnty. Sch. Bd.*, 107 F.3d 837, 839 (11th Cir. 1997) (“In order for a plaintiff to hold the state liable under the ‘special danger’ analysis, he must show that the state affirmatively placed him in a position of danger which was distinguishable from that of the general public.”).

III. *The Landscape of Mental Health Law and Public Psychiatric Hospitalization*

This Part begins by reviewing the general laws governing voluntary and involuntary hospitalization. Then, it discusses forces that transformed state hospitals in the last several decades, affecting the voluntary-hospitalization context.

A. *The Current Law of Voluntary and Involuntary Admissions*

Patients with acute mental health needs¹³⁷ can be admitted to a psychiatric facility in a variety of ways.¹³⁸ If the individual

137. This Note addresses “civil” mental health patients, as opposed to “forensic” patients who are committed to state hospitals through the criminal judicial system. Although beyond this Note’s scope, forensic patients represent a growing portion of state-hospital populations, and this trend impacts the state-hospital system generally. *Infra* notes 181–85 and accompanying text.

138. For the provisions of each state’s statute governing inpatient mental health treatment, see 22 ALA. CODE ch. 52, art. 1 (2012); 47 ALASKA STAT. ch. 30, arts. 8–9 (2012); 36 ARIZ. REV. STAT. ANN. ch. 5 (2012); 20 ARK. CODE ANN. ch. 47, subch. 2 (2012); CAL. WELF. & INST. CODE div. 5 pt. 1, div. 6 pt. 1, ch. 1 (2012); 27 COLO. REV. STAT. art. 65 (2012); 17A CONN. GEN. STAT. ch. 319I, pt. II (2012); 16 DEL. CODE ANN. chs. 50–51 (2012); 21 D.C. CODE ch. 5 (2012); XXIX FLA. STAT. ch. 394, pt. 1 (2012); 37 GA. CODE ANN. ch. 3, arts. 1–2 (2012); 19 HAW. REV. STAT. ch. 334, pts. IV–V (2012); 66 IDAHO CODE ANN. ch. 3 (2012); 405 ILL. COMP. STAT. Act 5, ch. 3 (2012); 12 IND. CODE art. 26 (2012); VI IOWA CODE ch. 229 (2012); 59 KAN. STAT. ANN. Art. 29 (2012); XVII KY. REV. STAT. ANN. ch. 202A (2012); 28 LA. REV. STAT. ANN. ch. 1, part III (2012); 34-B ME. REV. STAT. ch. 3, subch. 4 (2012); 10 MD. CODE ANN., HEALTH–GEN. subtit. 6–8 (2012); XVII MASS. GEN. LAWS ch. 123 (2012); 330 MICH. COMP. LAWS ch. 4 (2012); MINN. STAT. ch. 253B (2012); 41 MISS. CODE ANN. ch. 21 (2012); XL MO. REV. STAT. ch. 632 (2012); 53 MONT. CODE ANN. ch. 21 (2012); 71 NEB. REV. STAT. art. 9 (2012); 39 NEV. REV. STAT. ch. 433A (2012); X N.H. REV. STAT. ANN. ch. 135-C (2012); 30 N.J. STAT. ANN. subtit. 1, ch. 4, art. 3 (2012); N.M. STAT. ANN. ch. 43, art. 1 (2012); N.Y. MENTAL HYG. LAW ch. 27, tit. B, art. 9 (2012); N.C. GEN. STAT. ch. 122C, art. 5 (2012); 25 N.D. CENT. CODE ch. 25-03.1 (2012); LI OHIO REV. CODE ANN. ch. 5122 (2012); 43a OKLA. STAT. ch. 1, § 5 (2012); 35 OR. REV. STAT. ch. 426 (2012); 50 PA. CONS. STAT. ch. 15 (2012); 40.1 R.I. GEN. LAWS ch. 5 (2012); 44 S.C. CODE ANN. ch. 17 (2012); S.D. CODIFIED LAWS ch. 27a (2012); 33 TENN. CODE ANN. ch. 6 (2012); 7 TEX. HEALTH & SAFETY CODE ANN. subtit. C (2012); 62a UTAH CODE ANN. ch. 15, pt. 6 (2012); 18 VT. STAT. ANN. pt. 8 (2012); 37.2 VA. CODE ANN. subtit. III (2012); WASH. REV. CODE ch. 71.05 (2012); W.V. CODE ch. 27, arts. 1, 4–5 (2012); WIS. STAT. ch. 51 (2012); 25 WYO. STAT. ANN. ch. 10, art. 1 (2012).

agrees to the admission and gives informed consent, then he may be admitted voluntarily.¹³⁹

Voluntary patients can be further subdivided into two categories: pure voluntary or conditional voluntary. Under a “pure” or “informal” voluntary admission, a patient can leave the hospital whenever he chooses.¹⁴⁰ This freedom to walk out of the hospital may compromise therapeutic interventions, and so states often restrict pure voluntary admissions either by law or by policy and favor “conditional” or “formal” voluntary admissions.¹⁴¹ Typically, a formally voluntary patient who requests to leave the facility may be detained for a statutorily defined period—usually a few days—during which time the clinical staff evaluates whether the patient requires involuntary commitment.¹⁴² Based on this evaluation, clinical staff may institute involuntary commitment proceedings if warranted, and otherwise must discharge the patient once the statutory holding period elapses.¹⁴³

139. See APPELBAUM & GUTHEIL, *supra* note 46, at 43 (noting that all states currently allow voluntary admission).

140. *Id.* See, e.g., MICH. COMP. LAWS § 330.1412 (2012) (“An informal voluntary patient shall be allowed to terminate his hospitalization and leave the hospital at any time during the normal day shift hours of the hospital, and the hospital shall so inform the patient at the time he is hospitalized.”).

141. APPELBAUM & GUTHEIL, *supra* note 46, at 43. See, e.g., MICH. COMP. LAWS § 330.1411 (restricting informal voluntary hospitalizations by requiring that “the hospital director consider[] the individual to be clinically suitable for that form of hospitalization”).

142. APPELBAUM & GUTHEIL, *supra* note 46, at 43. For examples of state statutes allowing voluntary patients to be prevented from leaving the state hospital at will for a specific period of time, see ALASKA STAT. § 47.30.685 (2012) (48-hour hold); ARIZ. REV. STAT. ANN. § 36-519(B) (2012) (24-hour hold, excluding weekends and holidays); CONN. GEN. STAT. § 17a-506(a) (2012) (3-day hold); DEL. CODE ANN. tit. 16, § 5123(d) (2012) (5-day hold); FLA. STAT. § 394.4625(2)(a)(2) (2012) (3-day hold, excluding holidays and weekends); GA. CODE ANN. § 37-3-22(a) (2012) (72-hour hold, excluding Sundays and legal holidays); 405 ILL. COMP. STAT. 5/3-403 (2012) (5-day hold, excluding weekends and holidays); MICH. COMP. LAWS § 330.1452 (2012) (7-day hold, excluding weekends and holidays); 50 PA. CONS. STAT. § 4403(c) (2012) (10-day hold); WYO. STAT. ANN. § 25-10-108 (2012) (24-hour hold).

143. E.g., ARIZ. REV. STAT. ANN. § 36-519(B); CONN. GEN. STAT. § 17a-506(a); DEL. CODE ANN. tit. 16, § 5123(d)(3); FLA. STAT. § 394.4625(2)(a); 405 ILL. COMP. STAT. 5/3-403; 50 PA. CONS. STAT. § 4403(c).

The term “voluntary” is misleading. These admissions often involve coercive factors like criminal charges or family pressures.¹⁴⁴ Additionally, not only do the locked doors mean that voluntary patients are physically restricted from walking out of the facility, but most voluntary patients are legally restricted from leaving the hospital at will.¹⁴⁵

Alternatively, involuntary civil commitment procedures are available to hospitalize individuals who either refuse to consent to treatment or who lack capacity to consent.¹⁴⁶ Some baseline constitutional standards limit state laws.¹⁴⁷ States cannot involuntarily confine an individual simply because he has a mental illness: commitment requires that a mental illness is causing a person to pose some danger to himself or to others.¹⁴⁸ Civil commitment also demands that a state prove, by clear and convincing evidence, that commitment is appropriate under state law.¹⁴⁹

Within these constitutional constraints, states enact varying laws. Most states permit emergency commitment based on a clinical psychiatric evaluation of statutory criteria, allowing for short-term, temporary hospitalization until a judicial hearing can be convened.¹⁵⁰ Commitment hearings are formal proceedings

144. See RAYMOND L. SPRING ET AL., PATIENTS, PSYCHIATRISTS & LAWYERS: LAW & THE MENTAL HEALTH SYSTEM 374 (2d ed. 1997) (“A high percentage of ‘voluntary’ patients are in the hospital only because of external coercion of some form.”); Janet A. Gilboy & John R. Schmidt, “Voluntary” Hospitalization of the Mentally Ill, 66 NW. U. L. REV. 429, 430 (1971) (arguing that voluntary hospitalization usually involves some degree of coercion).

145. APPELBAUM & GUTHEIL, *supra* note 46, at 39. See also *supra* note 142 (collecting state statutes permitting state hospitals to hold voluntary patients for evaluation after the patient requests to be discharged).

146. See APPELBAUM & GUTHEIL, *supra* note 46, at 40–42 (discussing the history of, and rationales for, civil commitment).

147. See *id.* at 42–45 (reviewing the standards governing civil commitment).

148. See O’Connor v. Donaldson, 422 U.S. 563, 576 (1975) (“[A] State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom.”).

149. See Addington v. Texas, 441 U.S. 418, 431 (1979) (ruling that due process demands clear and convincing evidence because this standard “strikes a fair balance between the rights of the individual and the legitimate concerns of the state”).

150. See APPELBAUM & GUTHEIL, *supra* note 46, at 42–43 (explaining that emergency commitments vary in length from two days to three weeks and

where judicial officers preside and patients are afforded some due process rights.¹⁵¹ State laws on involuntary commitment standards require different levels of “dangerousness” caused by a mental illness. Substantively, these laws generally encompass three elements: (1) the individual has a mental illness; (2) the individual is dangerous; and (3) the individual needs treatment.¹⁵² Some states are increasing commitment standards

providing information on different clinical and evidentiary requirements under state law to institute emergency commitment). *See, e.g.*, ARIZ. STAT. ANN. § 36-535(B) (2012) (6 business days); CONN. GEN. STAT. § 17a-502(a) (2012) (15 days); GA. CODE ANN. § 37-3-62 (2012) (15 days); 405 ILL. COMP. STAT. 5/3-706 (2012) (5 days).

151. *See* APPELBAUM & GUTHEIL, *supra* note 46, at 43 (explaining that in the vast majority of states, judges—rather than administrative officers or juries—decide civil commitment hearings). *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-505 (2012) (guaranteeing patients an independent evaluation of their condition); CAL. WELF. & INST. CODE § 5256.4 (2012) (guaranteeing patients counsel, the right to present evidence, and the right to cross-examination); GA. CODE ANN. § 37-3-1(8) (2012) (requiring that patients have “effective assistance of counsel,” that hearings be recorded, and giving patients subpoena power, among other procedural rights); MD. CODE ANN., HEALTH-GEN. § 10-631 (2012) (requiring that involuntarily admitted patients receive notice in plain language informing them of their rights to consult counsel, and requiring that if the patient cannot understand the notice contents, his parent, guardian, or next-of-kin receive the information).

152. *See* APPELBAUM & GUTHEIL, *supra* note 46, at 43–45 (reviewing the differences among state civil commitment laws). For specific examples of state statutes setting forth the requirements for involuntary civil commitment, see DEL. CODE ANN. tit. 16 §§ 5001, 5010 (2012) (requiring that mental illness “renders [a] person unable to make responsible decisions with respect to the person’s hospitalization” and that the person pose “a real and present threat” of harm without immediate hospitalization); FLA. STAT. § 394.4667(1) (2012) (requiring serious mental illness and either that the person pose a harm to himself or others, or that he is unable to function in the community); HAW. REV. STAT. § 334-60.2 (2012) (requiring that the person “is imminently dangerous to self or others, is gravely disabled or is obviously ill”); KY. STAT. § 202A.026 (2012) (requiring that the person present either a danger or threat of danger to self or others, and can reasonably benefit from treatment); MD. CODE ANN., HEALTH-GEN. § 10-632(g) (2012) (requiring a “mental disorder,” which requires inpatient care, and that the person “present[] a danger to the life or safety of the individual or of others”); MICH. COMP. LAW § 330-1401 (2012) (defining “person requiring treatment” to include an individual who, because of mental illness, cannot attend to his basic needs, or who cannot understand his need for treatment, is treatment noncompliant, and has consequently been violent or been placed in psychiatric facilities, prison, or jail twice in past forty-eight months).

by demanding proof of some threat, attempt, or actual occurrence of harm.¹⁵³

States continue to develop laws governing civil commitment. For example, most states have adopted “outpatient commitment” laws, which require certain patients to comply with psychiatric treatment in the community.¹⁵⁴ As states rework the laws governing commitment, the context of voluntary hospitalization evolves.¹⁵⁵

B. The Historical Context of Mental Health Law and Hospitalization

Mental health law and public hospitalization should be understood in historical context.¹⁵⁶ Sovereigns have confined mentally ill persons for centuries.¹⁵⁷ At common law, the

153. See APPELBAUM & GUTHEIL, *supra* note 46, at 43 (explaining that heightened proof standards are intended to make the commitment determination an objective decision).

154. See *id.* at 48 (discussing outpatient commitment laws). Only a few states use these laws regularly because most states lack needed clinical and administrative structures at this time. *Id.* The criteria for which individuals qualify for outpatient commitment vary; some states require a high likelihood that a patient will relapse into acute symptoms, while other states require a pattern of dangerousness. *Id.* For examples of state statutes governing outpatient commitment orders and standards, see ALA. CODE §§ 22-52-10.2 to -10.3 (2012); FLA. STAT. § 394.4655 (2012); GA. CODE ANN. §§ 37-3-90, 37-3-93 (2012) (permitting courts to order outpatient commitment for one-year periods if a physician concludes from examination that an individual “is a mentally ill person requiring involuntary treatment” and outpatient treatment is available); 50 PA. CON. STAT. § 4406(b) (2012) (“[A] court may permit partial hospitalization or outpatient care, or if at any time thereafter the director shall determine such partial hospitalization or outpatient care to be beneficial to the person so committed, the same may be permitted by said court upon application by the director.”).

155. See JOHN Q. LAFOND & MARY L. DURHAM, BACK TO THE ASYLUM: THE FUTURE OF MENTAL HEALTH LAW & POLICY IN THE UNITED STATES 53–56 (1992) (reviewing different proposals for modifying civil commitment law).

156. See PAUL S. APPELBAUM, ALMOST A REVOLUTION: MENTAL HEALTH LAW & THE LIMITS OF CHANGE 12–13 (1994) (arguing that examining the evolution of mental health laws in recent decades “strengthen[s] our understanding of the complex interaction of forces involved when the law is applied to the mentally ill”).

157. See Note, *Civil Commitment of the Mentally Ill: Theories and*

government was obligated to “take care of those who could not take care of themselves.”¹⁵⁸ American courts continued applying this rule, but legal procedures changed as psychiatry evolved.¹⁵⁹ In the twentieth century, mental health law and public psychiatric facilities transformed dramatically with regards to both the voluntary nature and the total number of admissions.

First, in the twentieth century voluntary admission became available and popular.¹⁶⁰ During the first half of the century, almost every psychiatric patient was admitted involuntarily.¹⁶¹ Involuntary admissions were preferred for administrative convenience and a general belief that “the presence of mental illness per se rendered a person incompetent to consent to hospitalization.”¹⁶² State hospitals were considered important institutions for social reform, with psychiatric professionals bestowed significant power over their patients.¹⁶³

Beginning in the 1950s, psychiatric professionals and patients’-rights advocates fought to increase voluntary treatment.¹⁶⁴ States responded, dramatically revising the laws governing admissions.¹⁶⁵ By the early 1970s, voluntary admissions became more common than involuntary admissions. Currently, most patients are admitted voluntarily when both

Procedures, 79 HARV. L. REV. 1288, 1288 (1966) [hereinafter *Commitment Theories & Procedures*] (discussing involuntary commitment at common law).

158. See, e.g., *Beverly’s Case*, (1603) 76 Eng. Rep. 1118 (K.B.) 1124–26; 4 Co. Rep. 123 b, 126 a–127 b (discussing the King’s duties to “lunatics” and “idiots”).

159. See *Commitment Theories & Procedures*, *supra* note 157, at 1288 (explaining that “lunatics” came to be seen as ill, rather than as cursed).

160. See APPELBAUM & GUTHEIL, *supra* note 46, at 38 (“[T]he idea that the mentally ill might be able to sign themselves into psychiatric hospitals voluntarily is a relatively new one.”).

161. See *id.* (“[B]y 1949 only 10% of patients were voluntarily admitted [to psychiatric hospitals].”). No state permitted voluntarily admission until 1881. *Id.*

162. *Id.*

163. See LAFOND & DURHAM, *supra* note 155, at 84 (stating that before civil rights reforms, state actors could “make virtually all decisions for patients”).

164. See *id.* (explaining that civil libertarians opposed involuntary confinement, while psychiatrists favored voluntary admissions because they led to more effective treatment).

165. *Id.*

private and public/state hospitals are considered.¹⁶⁶ Some states even adopted statutory presumptions or policy statements encouraging voluntary—rather than involuntary—admission and treatment.¹⁶⁷ In state hospitals, however, involuntary admissions have recently become more common than voluntary.¹⁶⁸

Second, in the late-twentieth century the number of state hospital beds—and subsequently, the number of state-hospital patients—declined dramatically. In the mid-1950s, over 500,000 mentally ill persons sat “warehoused” in state institutions for years without effective treatment and lacking a mechanism to obtain release.¹⁶⁹ By 2003, the number of state hospital beds had fallen by over 90%, down to 40,000 beds.¹⁷⁰

Deinstitutionalization grew from a combination of factors: changing societal attitudes about institutionalization; financial incentives to treat people in the community; new antipsychotic medications, allowing outpatient treatment; new federal

166. *Id.*

167. *See, e.g.*, ALASKA STAT. § 47.30.655(1) (2012) (“Persons [should] be given every reasonable opportunity to accept voluntary treatment before involvement with the judicial system.”); COLO. REV. STAT. § 27-65-101(d) (2012) (declaring that the legislature intends to “encourage the use of voluntary rather than coercive measures to provide treatment and care”).

168. *See* LAFOND & DURHAM, *supra* note 155, at 43 (noting the trend); *see also infra* notes 183–84 and accompanying text (explaining the relationship between deinstitutionalization and involuntary admissions, as well as the effect on the patient populations in state hospitals).

169. *See* LAFOND & DURHAM, *supra* note 155, at 85 (describing “inhumane conditions in mental hospitals” in the 1940s).

170. *See* Ronald W. Mandersheld, Joanne E. Atay & Raquel A. Crider, *Changing Trends in State Hospital Use from 2002–2005*, 60 PSYCHIATRIC SERVICES 1, 1 (2009) (discussing trends in state hospitals). In 2011, only 145,065 total adults received inpatient treatment in state hospitals—a number higher than the number of beds because it accounts for patients who were discharged and whose beds were filled by a subsequent admission. *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., ALABAMA 2011 MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS): CMHS UNIFORM REPORTING SYSTEM 9 (2011), <http://www.samhsa.gov/dataoutcomes/urs/2011/Alabama.pdf> (listing the total number of adults treated in state psychiatric hospitals throughout the United States in 2011). For data on each state in 2011, *see* 2011 CMHS Uniform Reporting System Output Tables, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <http://www.samhsa.gov/dataoutcomes/urs/urs2011.aspx> (last visited Feb. 3, 2013) (linking to each state’s uniform data for 2011, and comparing state data to national data) (on file with the Washington and Lee Law Review).

legislation aimed at building outpatient treatment centers; and civil liberties lawyers' advocacy.¹⁷¹ The civil liberties lawyers facilitated deinstitutionalization through several key lawsuits challenging hospital conditions and commitment procedures.¹⁷² These suits facially addressed civil rights violations in state hospitals, but were actually "targeted at closing down the hospitals."¹⁷³

Deinstitutionalization caused "staggering" effects on the mentally ill population and mental health services.¹⁷⁴ Although a full understanding of deinstitutionalization is beyond the scope of this Note, one important effect is relevant: The availability of state psychiatric hospitalization declined dramatically.¹⁷⁵ States have slashed the number of state hospital beds.¹⁷⁶ Because beds are scarce, states limit admission to patients with the severest symptoms.¹⁷⁷ The structure of healthcare funding for psychiatric

171. See Jeffrey L. Geller, *The Last Half-Century of Psychiatric Services as Reflected in PSYCHIATRIC SERVICES*, 51 *PSYCHIATRIC SERVICES* 41, 42–58 (2000) (providing a comprehensive overview of factors causing deinstitutionalization); see also Community Mental Health Centers Act, Pub. L. No. 88-164, tit. II, 77 Stat. 282, 290–94 (1963) (allocating federal funding to states that established agencies for administering outpatient mental health care).

172. See *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975) (ruling that civil commitment requires the patient be dangerous and unable to live safely in the community); *Wyatt v. Alderholt*, 503 F.2d 1305, 1313–14 (5th Cir. 1974) (upholding injunction ordering Alabama state hospitals to improve the condition and staffing ratios).

173. See E. FULLER TORREY, *THE INSANITY OFFENSE: HOW AMERICA'S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS* 4 (2008) (noting that many states responded to *Wyatt* and *O'Connor* by discharging patients).

174. *Id.* at 50.

175. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *FUNDING & CHARACTERISTICS OF STATE MENTAL HEALTH AGENCIES* 69 (2009) [hereinafter SAMHSA FUNDING REPORT] (discussing the trend in most states to decrease state hospital services).

176. *Id.* One effect of deinstitutionalization is that many people with severe mental illness are now institutionalized in prisons and jails rather than hospitals. See GRANT H. MORRIS, *REFUSING THE RIGHT TO REFUSE: COERCED TREATMENT OF MENTALLY DISORDERED PERSONS* 150–51 (2006) (stating that approximately 283,000 people with mental illness were incarcerated in a 1998 study—often for petty crimes—meaning that jails have become the largest mental health providers in the country).

177. See LAFOND & DURHAM, *supra* note 155, at 51–52 (describing how deinstitutionalization and the consequent shortage of state hospital services

services encourages this practice by covering a predetermined amount of care in private facilities.¹⁷⁸ State governments bear the entire cost of patients' treatment in state hospitals, incentivizing states not to admit patients with available insurance coverage into the state-funded public facilities.¹⁷⁹ As a result, the sickest individuals—those who run out of covered inpatient services—are more likely to be admitted to state hospitals.¹⁸⁰

The legal system also caused changes in state hospitals. State hospitals are also devoting more beds to forensic patients who come from the criminal system.¹⁸¹ In 2008, one-third of state-hospital patients had been criminally committed to the hospital.¹⁸² State psychiatric hospitals also recently witnessed a dramatic rise in the proportion of involuntarily committed patients, a trend that contrasts with the general rise of voluntary admissions noted above.¹⁸³ The trend back to involuntary commitment in state hospitals stems from increasing forensic populations and general goals underlying deinstitutionalization.¹⁸⁴ The proportional rise of involuntary patients indicates a corollary rise in the proportion of patients posing a risk of harm—a necessary precondition to involuntary commitment. State hospitals, then, face more violent patient populations.¹⁸⁵

The state hospital today differs sharply from the state hospital in previous decades.¹⁸⁶ The sweeping reforms, sharp

caused a heightened threshold for determining which individuals are admitted to state institutions).

178. See John Petril, *Ethics, Money, and the Problem of Coercion: Coercion in Managed Behavioral Health Care*, 40 ST. LOUIS U. L.J. 359, 370–71 (1996) (discussing the impact of mental health coverage on public hospitals).

179. *Id.*

180. *Id.*

181. See SAMHSA FUNDING REPORT, *supra* note 175, at 71 (stating that between 1993 and 2007, state hospital expenditures for forensic services increased from 10.7% to 36%).

182. *Id.*

183. See LAFOND & DURHAM, *supra* note 155, at 43 (suggesting a trend toward involuntary admissions in state hospitals).

184. *Id.* (explaining that in some states, public hospitals serve only involuntary patients in order to keep the patient census low).

185. *Id.* at 53.

186. See William H. Fisher, Jeffrey L. Geller & John A. Pandiani, *The*

budget cuts, and concentration of more violent and more acutely ill patients suggest that courts should carefully guard patients' rights. But voluntary patients' rights are murky, with circuits divided on how to properly analyze affirmative duties.¹⁸⁷

IV. Circuit Split over Affirmative Duties to Voluntary Patients

This distinction between patients admitted voluntarily versus involuntarily bears significance beyond just criteria for admission or discharge. Courts use this voluntary/involuntary distinction to determine whether the state owes a particular patient *Youngberg* rights, but the circuits disagree on how to properly analyze voluntary patients' rights.¹⁸⁸ This circuit split predates *DeShaney*, but since *DeShaney* was handed down, that decision drives the train in courts' analyses.¹⁸⁹ This Part examines two broad approaches that circuit courts take. First, several circuits look solely to a patient's formal status as a voluntary or involuntary patient.¹⁹⁰ Second, other circuits scrutinize the facts in each case, looking at the circumstances of a patient's hospitalization to determine whether the patient's commitment was voluntary or involuntary.¹⁹¹

Changing Role of the State Psychiatric Hospital, 28 HEALTH AFFAIRS 676, 676–81 (arguing that state hospitals evolved from being the primary treatment source for the mentally ill, and now primarily manage those people who cannot be managed elsewhere). The authors identify four groups of patients whom they predict will likely “define the state hospital’s mission for the foreseeable future”: (1) people with criminal justice histories; (2) forensic patients; (3) sexually dangerous persons; and (4) patients who are difficult to discharge, often because of the severity of their illness. *Id.* at 679–80.

187. See *infra* Part IV (discussing the circuit split).

188. See *supra* note 71 and accompanying text (stating *Youngberg*'s rule that involuntarily committed mental health patients are owed certain affirmative duties); *Lanman v. Hinson*, 529 F.3d 673, 682 n.1 (6th Cir. 2008) (noting the circuit split on whether states owe affirmative duties to voluntary patients).

189. See *Lanman*, 529 F.3d at 682 n.1 (discussing the circuit split both before and after *DeShaney*).

190. See *infra* Part IV.A (reviewing cases applying status-based tests).

191. See *infra* Part IV.B (reviewing cases applying fact-based tests).

A. A Status-Based Approach to Affirmative Duties

One group of circuit courts applies the general no-duty rule broadly when voluntary patients bring *Youngberg*-type claims premised on affirmative duties of care or protection.¹⁹² Basing their affirmative-duty analysis on the patients' formal admission status, these circuits interpret *DeShaney* to preclude affirmative duties for everyone except civilly committed patients.¹⁹³

*1. Sixth Circuit: Higgs v. Latham*¹⁹⁴

The Sixth Circuit applied a status-based analysis focused on the voluntary/involuntary distinction in *Higgs v. Latham*.¹⁹⁵ Josephine Higgs was admitted to Western State Hospital in complicated circumstances. Josephine was initially a patient at Grayson County Hospital.¹⁹⁶ Her husband observed her mental illness worsening during her treatment at Grayson, he petitioned a court to order Josephine to be involuntarily hospitalized at Western State, and the court granted this order.¹⁹⁷ Pursuant to this order, Josephine was transported via ambulance from Grayson to Western State, and was strapped down due to state officials' concern that she would harm herself.¹⁹⁸ Upon arriving at Western State, however, Josephine was allowed to sign herself in as a voluntary patient because the Western State staff were

192. See *infra* notes 222–57 and accompanying text (discussing cases highlighting the status-based analysis applied in the Sixth, First, and Fifth Circuits).

193. See *infra* notes 207, 234, 236, and 257 and accompanying text (discussing these circuits' interpretations of *DeShaney* as limiting affirmative duties to formally committed patients).

194. *Higgs v. Latham*, No. 91-5273, 1991 WL 216464, at *4 (6th Cir. Oct. 24, 1991) (per curiam) (affirming the district court's ruling that the state owed no affirmative duties to a patient who was sent to a hospital under judicial order, but admitted voluntarily due to a communication error in the emergency room).

195. *Id.*

196. *Id.* at *1, *5. The opinion provides scant information about the Grayson hospitalization; it is unclear whether Josephine was voluntarily admitted or whether this hospitalization was for psychiatric or medical treatment.

197. *Id.*

198. *Id.*

never informed about the prior court proceeding.¹⁹⁹ Had the hospital known about the court order, it would not have allowed Josephine to sign in as a voluntary patient.²⁰⁰ After Josephine was admitted, another patient sexually assaulted her, prompting Josephine and her husband to bring this § 1983 suit for monetary and injunctive relief.²⁰¹ The case first went before a magistrate judge, who denied the State's motion for summary judgment, finding a genuine factual dispute over whether Josephine was, in fact, a voluntary patient.²⁰² The district court reversed, granting summary judgment to the State on the grounds that Josephine was a voluntary patient with no constitutional right to affirmative care and protection.²⁰³

The Sixth Circuit agreed that Josephine, as a voluntary patient, had no positive rights.²⁰⁴ The court began by analyzing *Youngberg* and *DeShaney*.²⁰⁵ The court interpreted *Youngberg* as concluding that involuntary patients have affirmative rights, but as silent regarding voluntary patients.²⁰⁶ *DeShaney*, however, does apply to voluntary patients, and under *DeShaney*, affirmative duties depend "on the kind of restraint that disables a person from caring for himself."²⁰⁷ Applied to this case, the court reasoned that the state's court order did not amount to an actual restraint because it was "unexecuted and unknown" to the hospital.²⁰⁸ For the hospital to take on affirmative duties, the hospital must have restrained Josephine.²⁰⁹ And because the

199. *Id.* at *1–2.

200. *See id.* at *1 (containing the testimony about the admission procedures).

201. *Id.*

202. *Id.* at *2.

203. *Id.*

204. *See id.* at *4 ("If the district court was correct in concluding that Mrs. Higgs was a voluntary patient at Western State Hospital, then it follows that she had no constitutionally based right of action against any of the defendants.").

205. *See id.* at *2–4 (examining these cases).

206. *Id.* at *2.

207. *Id.* at *3.

208. *Id.*

209. *Id.* at *4.

hospital did not know about the court order and because Josephine signed voluntary admission papers, “there was no ‘affirmative act’ by the hospital to deprive her of liberty,” and so the state’s duty-to-protect was never triggered.²¹⁰

The majority rejected Josephine’s arguments that she was not competent to be voluntarily admitted and that hospital staff coerced her into signing the voluntary paperwork.²¹¹ First, regarding Josephine’s “allegedly confused state of mind,” the court refused to engage in this “highly problematic exploration of the state of mind of an acutely ill mental patient.”²¹² Second, the court rejected arguments that “advice” given by a nurse at Grayson that “it would be better for [Josephine] to admit herself voluntarily to Western State rather than being involuntarily committed there” amounted to constructive confinement.²¹³

Judge Suhrheinrich concurred in the ruling but disagreed with the majority’s analysis of the voluntary/involuntary distinction,²¹⁴ arguing that the majority misinterpreted *DeShaney*.²¹⁵ To start, Judge Suhrheinrich contended that “*DeShaney* [does not] control the outcome of this case.”²¹⁶ First, *DeShaney* does not preclude voluntary patients from establishing claims based on functional custody or on state-created danger.²¹⁷ With respect to functional custody, Judge Suhrheinrich suggested that affirmative duties may have been triggered on the several occasions when Josephine requested to leave Western State, “and permission was refused.”²¹⁸ With respect to state-created danger, affirmative duties may have been triggered when she was court-ordered for temporary commitment, given that Josephine probably would not have gone to Western State or signed

210. *Id.*

211. *See id.* at *4–5 (discussing Josephine’s claims that her admission was not voluntary).

212. *Id.* at *5.

213. *Id.*

214. *Id.* at *6 (Suhrheinrich, J., concurring).

215. *Id.*

216. *Id.*

217. *See id.* (“*DeShaney*’s custody test for liability may therefore be met *even after* it is shown that a patient was voluntarily admitted.”).

218. *Id.* at *6 n.1.

voluntary admission papers otherwise.²¹⁹ Overall, the concurrence is noteworthy for its recommendation that voluntary patients should be able to make out affirmative-duty claims based on functional custody or state-created danger.²²⁰

2. *First Circuit: Monahan v. Dorchester Counseling Center*²²¹

The First Circuit adopted a restrictive approach similar to the Higgs majority in *Monahan v. Dorchester Counseling Center*.²²² Mr. Monahan was a voluntary patient at a state-operated group home called Millie's Cottage.²²³ On the day the injury occurred, Mr. Monahan, accompanied by Cottage staff, went to a hospital emergency room and was evaluated for possible admission.²²⁴ The hospital staff determined that inpatient treatment was unnecessary and that he could return to the Cottage.²²⁵ While state employees were driving him back from the emergency room, Mr. Monahan jumped out of the car and walked toward an interstate highway.²²⁶ The driver, a state employee, did not call the police or try to stop Mr. Monahan; instead, he drove back to the group home and called a hospital, sending two other state employees to look for Mr. Monahan.²²⁷ During this time, a car struck Mr. Monahan, causing serious injury.²²⁸ Mr. Monahan then sued state officials for injunctive and compensatory relief stemming from his injuries, claiming they violated a duty to provide adequate

219. *Id.*

220. *Id.* at *6 (“*DeShaney* compels us to go beyond asking whether Higgs was a voluntary admittee. *DeShaney* demands that we examine the limitations imposed on Higgs while she was a resident at the state hospital.”).

221. *Monahan v. Dorchester Counseling Ctr.*, 961 F.2d 987, 991 (1st Cir. 1992) (ruling that a voluntary patient had no constitutional right to protection because the state did not restrict his liberties through civil commitment procedures).

222. *Id.*

223. *Id.* at 988.

224. *Id.*

225. *Id.*

226. *Id.* at 988–89.

227. *Id.* at 989.

228. *Id.*

supervision and treatment.²²⁹ The district court granted the defendants' motion to dismiss for failure to state a claim and also denied Mr. Monahan's motion to submit an amended complaint.²³⁰ Mr. Monahan appealed to the First Circuit.²³¹

In analyzing whether the state had violated any duty to Mr. Monahan, the First Circuit examined the relationship between the patient and the state. The facts differ from *Youngberg* because Mr. Monahan was not involuntarily committed.²³² The facts also differ from *DeShaney* because Mr. Monahan was living in a state-operated facility, rather than a private home.²³³ Despite these differences from *DeShaney's* facts, the court applied *DeShaney's* rationale—that the Due Process Clause does not generally impose affirmative duties—and determined that the state had assumed no such duty.²³⁴ “Because the state did not commit Monahan involuntarily, it did not take an ‘affirmative act’ of restraining his liberty.”²³⁵

The court rejected Mr. Monahan's arguments that *DeShaney's* exceptions for functional custody or state-created danger applied, basing its rejection on Mr. Monahan's voluntary status. First, while acknowledging that a state assumes affirmative duties when it uses coercive measures to restrict an individual's liberty,²³⁶ the court determined that the state had not coerced Mr. Monahan because it had not initiated formal commitment proceedings.²³⁷ The court must look to whether the state's affirmative actions caused Mr. Monahan to give up some liberties.²³⁸ Mr. Monahan's mental illness—not the state—

229. *Id.*

230. *See id.* at 990 (discussing the history in the lower court).

231. *Id.*

232. *See id.* (comparing the instant case to *Youngberg*).

233. *See id.* (“His relationship to the state was therefore considerably closer than that of the plaintiff in *DeShaney*.”).

234. *See id.* at 990–91 (stating that under *DeShaney*, Mr. Monahan “failed to state a viable claim for denial of substantive due process”).

235. *Id.* at 991.

236. *See id.* at 992 n.5 (interpreting *DeShaney's* language to mean that “where the state's coercive power is not involved, there can be no *constitutional* (as opposed to tort) right to careful treatment”).

237. *Id.* at 992.

238. *Id.* Although the circuit had ruled in pre-*DeShaney* cases that

deprived him of his liberty.²³⁹ Second, the state-created danger argument failed for similar reasons. The state's actions might have made Mr. Monahan more vulnerable to harm.²⁴⁰ Again, Mr. Monahan "voluntarily availed himself of a Commonwealth service," and so the state did not take on affirmative duties.²⁴¹ Overall, then, the circuit's analysis turned primarily on Mr. Monahan's voluntary status—the state owed him no affirmative duties because the state had not initiated formal commitment proceedings.

3. *Fifth Circuit: Walton v. Alexander*²⁴²

The Fifth Circuit, sitting en banc, adopted a similar analysis in *Walton v. Alexander*.²⁴³ Christopher Walton was a voluntary residential student at the Mississippi School for the Deaf.²⁴⁴ Another student sexually assaulted Christopher several times.²⁴⁵ The state became aware of the first assault and instituted precautions, such as separating the students into different dormitories.²⁴⁶ But then budgetary constraints caused the school to close one of the dormitories and the boys were placed back in the same building, where the student sexually assaulted Christopher again.²⁴⁷ The district court denied the defendant's

voluntary patients might have affirmative constitutional rights because of severe symptoms or de facto involuntary conditions, the court suggested that *DeShaney* demands different analysis. *Id.*

239. *See id.* ("His helplessness was not attributable to the [State taking] him into custody involuntarily.").

240. *See id.* at 993 (agreeing with Mr. Monahan's argument that "the Commonwealth could plausibly be said to have rendered him more vulnerable to danger").

241. *See id.* ("The Commonwealth did not force Monahan, against his will, to become dependent on it.").

242. *Walton v. Alexander*, 44 F.3d 1297, 1306 (5th Cir. 1995) (en banc) (ruling that a state has no duty to protect persons within its custody unless the state has taken affirmative steps to involuntarily confine them).

243. *Id.*

244. *Id.* at 1299.

245. *Id.* at 1299–1300.

246. *Id.*

247. *Id.* at 1300.

motion for summary judgment on qualified immunity grounds. The defendant filed an interlocutory appeal, in which a panel majority held that Superintendent Alexander had a special relationship with Christopher and, therefore, Christopher was entitled to *Youngberg* rights.²⁴⁸ The Fifth Circuit then took up this interlocutory appeal en banc, reversing the panel majority's decision and the district court's denial of immunity.²⁴⁹

The panel majority had ruled that Christopher was owed affirmative duties because the state had exercised functional custody.²⁵⁰ Looking to language in *DeShaney* suggesting that states trigger affirmative duties by restraining someone's liberty in a manner similar to incarceration, the court examined the factual setting of Christopher's relationship to the state.²⁵¹ Many facts indicated "a significant custodial component" in this relationship: Christopher lived at the school; the school enforced strict rules; Christopher was "not free to leave" the school at will; and economically, most families had "no other viable option" for educating handicapped children.²⁵² These facts combined to make Christopher "dependent on the School for his basic needs and [he] lost a substantial measure of his freedom to act."²⁵³ The state, therefore, had functional custody and was obligated to provide Christopher with a reasonably safe environment.²⁵⁴

The en banc panel disagreed. Summarizing its analysis, the Fifth Circuit explained, "we have followed [*DeShaney's*] language strictly."²⁵⁵ If a state has affirmatively exercised its power to take custody over an individual against his will, then the state assumes affirmative duties.²⁵⁶ But Christopher had "voluntarily subjected himself" to the state's custody and had "the option of

248. *See id.* (discussing the prior history).

249. *Id.* at 1299.

250. *See* Walton v. Alexander, 20 F.3d 1350, 1355 (5th Cir. 1994) (finding an affirmative duty from functional custody), *rev'd en banc*, 44 F.3d 1297, 1303 (5th Cir. 1995) (en banc).

251. *See id.* (describing the facts that indicate a custodial relationship).

252. *Id.*

253. *Id.*

254. *Id.*

255. Walton v. Alexander, 44 F.3d 1297, 1303 (5th Cir. 1995) (en banc).

256. *Id.*

leaving at will.”²⁵⁷ Therefore, the state had no affirmative duty to protect him.²⁵⁸

Judge Parker concurred specially in an opinion joined by three other circuit judges.²⁵⁹ The concurrence disagreed with *DeShaney’s* proper interpretation, asserting that the en banc majority read *DeShaney* “erroneously” to require “a bright line rule that represents an extreme constitutional viewpoint.”²⁶⁰ But this bright-line rule arbitrarily limits constitutional rights without accurately reflecting the facts of any given case.²⁶¹

The concurrence argued that the court should apply a factor-based test assessing the quality and nature of the relationship between patient and state.²⁶² Reasoning that this test comports with *DeShaney*, Judge Parker looked to the *DeShaney* opinion.²⁶³ While *DeShaney* limited affirmative duties to contexts such as involuntary commitment and incarceration, the majority was explicit that “other similar restraint[s] of personal liberty” will trigger affirmative duties.²⁶⁴ Thus, the concurrence argued, courts

257. *See id.* at 1305 (analyzing Christopher’s case in light of *DeShaney*).

258. *Id.*

259. *Id.* at 1306 (Parker, J., concurring).

260. *Id.*

261. *See id.* at 1309 (stating that the majority’s rule arbitrarily assigns constitutional rights, and providing hypothetical illustrations of how the bright-line test fails to reliably and accurately measure state control).

262. *See id.* at 1309–10

Instead of asking whether a person was taken into custody involuntarily, we should consider several factors to determine whether a special relationship exists in a particular case: 1) the authority and discretion state actors have to control the environment and 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.

263. *See id.* at 1307–08 (analyzing *DeShaney’s* majority opinion).

264. *Id.* (citing *DeShaney v. Winnebago Cnty. Dep’t of Soc. Servs.*, 489 U.S. 189, 200 (1989)). The concurrence pointed out the absurdity created by the majority’s holding: “[S]tate actors entrusted with the responsibility to care for and protect our most vulnerable citizens may do so with constitutional impunity,” while incarcerated “criminals are wrapped in the protective cloak of the constitution.” *Id.* at 1310.

must analyze the restraints on liberty in order to determine whether constitutional duties are at play.²⁶⁵

The *Walton* majority, however, like the *Monahan* and *Higgs* courts, determined that affirmative-duty analysis turns on formal status. These courts interpret *DeShaney* to require involuntary commitment procedures before a state takes on affirmative duties.²⁶⁶ And, as the *Higgs* and *Walton* concurrences point out (albeit, critically),²⁶⁷ these courts avoid a fact-heavy analysis. Only facts about commitment proceedings are relevant, and the patient's formal status is determinative.

B. A Fact-Based Approach to Affirmative Duties

Other circuit courts reject a strict status-based approach, concluding that voluntary status does not per se preclude *Youngberg* rights. Prior to *DeShaney*, several circuit courts ruled that voluntary status is irrelevant in these cases.²⁶⁸ After *DeShaney*, the Third, Eighth, and Eleventh Circuits continue to look beyond formal voluntary/involuntary labels.

265. *Id.* at 1310. Applying its test, the concurrence concluded that the state exercised sufficient control over Christopher to trigger affirmative duties. *Id.* However, the concurrence determined that the state actors were not liable because the plaintiffs failed to prove the state violated its duty by acting with deliberate indifference. *Id.* at 1307.

266. *See supra* notes 207, 235, 256 and accompanying text (discussing how the First, Sixth, and Fifth Circuits applied *DeShaney* to require involuntary commitment).

267. *See supra* notes 214–20 and accompanying text (summarizing Judge Suhrheinrich's concurrence in *Higgs*); *supra* notes 259–65 and accompanying text (summarizing Judge Parker's concurrence in *Walton*).

268. *See, e.g., Soc'y for Good Will to Retarded Children v. Cuomo*, 737 F.2d 1239, 1246 (2d Cir. 1984) (ruling that patients' voluntary status is "irrelevant" in determining whether *Youngberg* rights apply, reasoning that *Youngberg*'s analysis applies equally to voluntary and involuntary patients); *Goodman v. Parwatarikar*, 570 F.2d 801, 804 (8th Cir. 1978) (ruling that, although a state hospital has no obligation to admit anyone, the state owes affirmative duties to those individuals that it does admit); *Harper v. Cserr*, 544 F.2d 1121, 1124 (1st Cir. 1976) (ruling that a voluntary patient may assert a constitutional right to affirmative protection by establishing a sufficient level of helplessness).

*1. Eleventh Circuit: Spivey v. Elliot*²⁶⁹

The Eleventh Circuit ruled in *Spivey v. Elliot*²⁷⁰ that whether a child receiving treatment voluntarily in a state-operated residential program has *Youngberg* rights depends on the level of control the state exercises.²⁷¹ Tremain Spivey was a residential student at Georgia's School of the Deaf, living at the school five days per week, with his mother's consent.²⁷² A thirteen-year-old classmate sexually assaulted Tremain on several occasions.²⁷³ Tremain's mother subsequently withdrew him from the school and filed a § 1983 suit against the school, claiming that the school violated its duty to provide a safe environment under *Youngberg*.²⁷⁴ The district court granted the defendant's motion for summary judgment on qualified immunity grounds.²⁷⁵ Tremain appealed.²⁷⁶

The Eleventh Circuit issued two opinions responding to the State's argument that Tremain had no right to its protection because he was at the school voluntarily.²⁷⁷ In its first ruling, the Eleventh Circuit disagreed with the State, interpreting *DeShaney* to mean that a state owes affirmative duties when it exercises sufficient control and dominion over an individual.²⁷⁸ The control and dominion requirement might be met whether a patient is voluntary or involuntary.²⁷⁹ Regarding Tremain's voluntary status, "[t]he outcome of the case cannot turn on that

269. *Spivey v. Elliot*, 29 F.3d 1522, 1526 (11th Cir. 1994) (ruling that the state owed affirmative duties to a voluntary patient under *DeShaney*'s functional custody exception).

270. *Id.*

271. *Id.*

272. *Id.* at 1523.

273. *Id.*

274. *Id.* at 1523–24.

275. *Id.* at 1524.

276. *Id.*

277. *Id.* at 1526.

278. *See id.* ("The question is not so much *how* the individual got into state custody, but to what extent the State exercises dominion and control over that individual.").

279. *Id.*

distinction.”²⁸⁰ The court, however, affirmed the district court’s grant of summary judgment to the State on qualified immunity grounds.²⁸¹

In a later ruling, the court revisited its decision *sua sponte*, backing away from its affirmative duty analysis.²⁸² Pointing out that Tremain’s claim failed on qualified immunity, the court decided that its affirmative duty analysis was unnecessary and should not serve as precedent.²⁸³ Therefore, while *Spivey*’s first ruling—that affirmative duties may be found independently of the voluntary/involuntary distinction—is not binding, the analysis is informative as to how the Eleventh Circuit might rule in the absence of qualified immunity issues.²⁸⁴

2. Eighth Circuit: *Kennedy v. Schafer*²⁸⁵ and *Shelton v. Arkansas Department of Human Services*²⁸⁶

The Eighth Circuit applied an analysis similar to the Eleventh Circuit’s first *Spivey* decision in *Kennedy v. Schafer*.²⁸⁷

280. *Id.*

281. *See id.* at 1527 (deciding that the petitioner failed to show that his constitutional right was clearly established at the time the harm occurred).

282. *See Spivey v. Elliot*, 41 F.3d 1497, 1498 (11th Cir. 1995) (“Upon reconsideration on the suggestion of other members of this Court, we now think it enough to decide that there was no clearly established constitutional right allegedly violated by the defendants.”).

283. *See id.* at 1499 (“[T]his panel has chosen to withdraw all of its prior opinion which relates to whether the complaint alleges a constitutional right.”).

284. The Supreme Court has ruled that courts should analyze whether a constitutional duty is established before reaching qualified immunity questions. *See Siegert v. Gilley*, 500 U.S. 226, 232 (1991) (discussing the proper structure of analysis).

285. *Kennedy v. Schafer*, 71 F.3d 292, 295 (8th Cir. 1995) (remanding case in which voluntarily admitted psychiatric patient committed suicide and instructing lower court that if based on patient’s condition at time of suicide the facility could have lawfully detained her, then state had affirmative duty), *cert. denied*, 518 U.S. 1018 (1996).

286. *Shelton v. Ark. Dep’t of Human Servs.*, 677 F.3d 837, 839, 842 (8th Cir. 2012) (affirming that state owed no affirmative duties when voluntarily admitted psychiatric patient attempted suicide and, upon finding her alive, medical staff did not administer mouth-to-mouth resuscitation, leading to the patient’s death).

287. *Kennedy*, 71 F.3d. at 295.

The patient in this case was Kathleen Kennedy, a fifteen-year-old girl who was admitted voluntarily to Hawthorn Children's Psychiatric Hospital in Missouri.²⁸⁸ The hospital knew Kathleen was suicidal and her clinicians ordered suicide precautions, requiring that the nursing staff keep Kathleen within their eyesight.²⁸⁹ About a week after these precautions began, the hospital unit was short-staffed, and the nursing supervisor declined to schedule another nurse to work the evening shift.²⁹⁰ That evening, April 8, 1992, the nursing staff did not keep Kathleen within their eyesight.²⁹¹ After 2:30 PM, staff did not see Kathleen for over three hours.²⁹² At 5:10 PM, staff discovered that Kathleen had committed suicide.²⁹³ Her parents sued the State under § 1983, claiming that the hospital violated its duty to provide a safe and humane environment.²⁹⁴ The district court granted summary judgment to the State on the grounds that it did not owe Kathleen affirmative *Youngberg* duties because of her voluntary status, and alternatively on qualified immunity grounds.²⁹⁵ Kathleen's parents appealed.²⁹⁶

In analyzing whether the state owed Kathleen such a duty, the Eighth Circuit focused on the degree of control the state exercised over Kathleen.²⁹⁷ Its analysis resembles the Eleventh Circuit's initial approach in *Spivey*, which found that Georgia's control over Tremain Spivey placed him within *DeShaney's* functional custody exception.²⁹⁸ The Eighth Circuit, however,

288. *Id.* at 293.

289. *Id.*

290. *Id.*

291. *Id.*

292. *Id.*

293. *Id.*

294. *Id.* at 294.

295. *Id.*

296. *Id.* at 293.

297. *See id.* (agreeing with the Kennedy's argument that "the amount of control the state actors . . . exerted over Kathleen's life" is relevant to whether affirmative duties exist).

298. *See Spivey v. Elliot*, 29 F.3d 1522, 1526 (11th Cir. 1994) ("The question is not so much *how* the individual got into state custody, but to what extent the State exercises dominion and control over that individual.").

looked to whether Missouri exercised such control over Kathleen that “she had become, in effect, an involuntary patient.”²⁹⁹ Pointing out that Missouri law restricts patients who pose a substantial risk of harming themselves from leaving the hospital,³⁰⁰ and that this statutory language appeared on the voluntary admission papers Kathleen’s mother had signed, the court reasoned that Kathleen might not have enjoyed an absolute right to leave the hospital.³⁰¹ The court remanded the case for a factual determination of how much control the state exercised over Kathleen.³⁰²

To support its analysis, the court pointed to *DeShaney*’s language that a state owes affirmative duties when it exercises functional custody, thereby creating a situation “sufficiently analogous” to involuntary hospitalization.³⁰³ It applied this language, however, not asking whether Kathleen’s situation was “analogous” to an involuntary patient’s, but by asking whether Kathleen had, in fact, become an involuntary patient.³⁰⁴ Through this analytic step, the court explicitly avoided addressing whether *Youngberg* might apply to voluntary patients.³⁰⁵ And while the

299. *Kennedy v. Schafer*, 71 F.3d 292, 296 (8th Cir. 1995), *cert. denied*, 518 U.S. 1018 (1996).

300. *Id.* at 295–96. The court arrived at this interpretation of Missouri law by reading three separate statutory provisions together. First, state statutes give the hospital discretion to refuse to discharge a minor psychiatric inpatient who is substantially at risk of harming herself, covering patients at risk for suicide. MO. REV. STAT. §§ 632.155(2), 632.005(10)(a) (2012). Second, if state psychiatric workers become aware that any person—including non-patients—is likely to cause serious harm because of a psychiatric illness, then the state actor is under a duty to evaluate the person’s condition. *Id.* § 632.300(1). Third, if the state actor concludes that this person poses an “imminent” risk of substantial harm because of a psychiatric illness, then the actor is obligated to initiate procedures for involuntary hospitalization. *Id.* § 632.300(2).

301. *Kennedy*, 71 F.3d at 295.

302. *Id.* at 296.

303. *Id.* at 295 (quoting *DeShaney v. Winnebago Cnty. Dep’t of Soc. Servs.*, 489 U.S. 189, 201 n.9 (1989)).

304. *See id.* (stating that factors such as Kathleen’s clinical condition and state law “may have converted her status to that of an involuntary patient”); *id.* at 296 (“Facts change, and legal status follows facts.”).

305. *Id.* at 295 (“[T]his disposition makes it unnecessary to address the question whether a voluntary mental patient enjoys the same due process protections as an involuntary patient.”).

Kennedy court looked beyond Kathleen's formal status, it nevertheless grounded its decision on her de facto status as either a voluntary or an involuntary patient.³⁰⁶

The Eighth Circuit recently revisited its *Kennedy* decision in *Shelton v. Arkansas Department of Human Services*, clarifying the circuit's approach to voluntarily admitted patients.³⁰⁷ The facts in *Shelton* resemble those in *Kennedy*, with several key differences.³⁰⁸ Brenda Shelton signed in as a voluntary patient at Arkansas State Hospital because she was suicidal.³⁰⁹ The clinical staff initially placed her on "suicide watch," but—unlike Kathleen Kennedy—these precautions were eventually removed.³¹⁰ Three days later, nursing staff found Brenda in her room and discovered that Brenda had hanged herself.³¹¹ Brenda was unconscious, but still alive.³¹² The clinical staff, however, refused to provide mouth-to-mouth resuscitation.³¹³ Medical equipment that might have helped revive Brenda was locked in a storage room; the room was unavailable because a nurse had locked the key inside the room.³¹⁴ Brenda died a few days later.³¹⁵ The administrator of her estate sued the State, the hospital, and several clinicians individually, alleging, *inter alia*, that the hospital violated Brenda's substantive due process rights.³¹⁶ The district court dismissed the lawsuit for failing to state a claim, ruling that the state did not owe Brenda affirmative duties because she was a voluntary patient.³¹⁷

306. *See id.* at 296 (stating that Kathleen's formal status is not determinative, and that the lower court must resolve whether Kathleen was, in effect, involuntary).

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

308. *Compare id.* at 839 (explaining the facts in *Shelton*), with *supra* notes 288–94 and accompanying text (explaining the facts in *Kennedy*).

309. *Shelton*, 677 F.3d at 839.

310. *Id.*

311. *Id.*

312. *Id.*

313. *Id.*

314. *Id.*

315. *Id.*

316. *Id.*

317. *Id.* at 839–40.

On appeal to the Eighth Circuit, the arguments concentrated on *Kennedy's* proper application.³¹⁸ Brenda's estate argued that, under *Kennedy*, affirmative duties were triggered when the hospital staff discovered that Brenda had hanged herself.³¹⁹ The court pointed out that the estate "appear[ed] to concede" that duties were *not* triggered when the clinical staff removed Brenda's suicide precautions several days before.³²⁰ This fact differentiated Brenda's circumstances from Kathleen Kennedy's.³²¹

The two cases were further distinguished, the court explained, by whether the alleged constitutional violation occurred before or after the patient attempted suicide.³²² The nurses failed to sufficiently monitor Kathleen *before* she committed suicide, while the alleged wrong in Brenda's case occurred *after* the staff found her still alive.³²³ Brenda was "wholly incapacitated" and incapable of further harming herself.³²⁴ Consequently, any state statutes requiring involuntary treatment for persons at risk of self-harm could not have converted Brenda's voluntary admission to involuntary (as was the case in *Kennedy*).³²⁵ Moreover, the court expressed reluctance to impose potential liability on state actors to emergency situations, which require "split-second, emergency-care decisionmaking."³²⁶ Characterizing *Kennedy* as "a very close

318. *See id.* at 840–42 (considering competing interpretations of the *Kennedy* decision and its impact on the instant case).

319. *Id.* at 840–41 (describing petitioner's arguments).

320. *Id.* at 841.

321. *See id.* (explaining that *Kennedy* involved "at least a degree of" liberty deprivation because Kathleen was on suicide precautions, differentiating that case from *Shelton*, in which Brenda was not on suicide precautions when the injury occurred).

322. *Id.*

323. *Id.*

324. *See id.* at 842 (stating that, as a factual matter, Brenda posed no risk of additional self-harm because she was unconscious).

325. *See id.* (reasoning that Brenda's situation resembled an unconscious patient brought into an emergency room; in such a situation, the state is not constitutionally obligated to provide treatment).

326. *Id.*

case,” the court declined to extend *Kennedy*’s rule, although it left the rule intact.³²⁷

3. *Third Circuit: Torisky v. Schweiker*³²⁸

The Third Circuit also applied a fact-intensive analysis in *Torisky v. Schweiker*.³²⁹ In this case, the guardians of twenty individuals with mental retardation sued Pennsylvania officials after the patients were transferred between facilities.³³⁰ The patients were all being treated at the Western Center, and when the state decided to close this facility, it transferred the patients to other state facilities.³³¹ The patients then brought § 1983 claims seeking monetary and injunctive relief.³³² The circuit court reviewed the district court’s ruling that voluntary patients share the same constitutional rights under *Youngberg* that involuntarily committed patients enjoy.³³³

To resolve this issue, the court examined *DeShaney* and other circuit rulings. From the case law, the court first concluded that not every mental health patient has *Youngberg* rights.³³⁴ Even though voluntary patients reside in the state’s custody, the state may not have deprived them of their liberty.³³⁵ The court

327. *Id.*

328. *Torisky v. Schweiker*, 446 F.3d 438, 447 (3d Cir. 2006) (concluding that whether a voluntary patient possesses due process rights requires “looking beyond the label of an individual’s confinement to ascertain whether the state has deprived an individual of liberty in such a way as to trigger *Youngberg*’s protections”).

329. *Id.*

330. *Id.* at 441.

331. *Id.*

332. *Id.*

333. *See id.* (defining the issue as “whether a state’s affirmative duty under the Due Process Clause to care for and protect a mental health patient in state custody depends upon the individual’s custody being involuntary”).

334. *See id.* at 444 (“[T]he substantive rights recognized in *Youngberg* are limited to persons whose personal liberty has been substantially curtailed by the state.” (quoting *Fialkowski v. Greenwich Home for Children*, 921 F.2d 459, 465 (3d Cir. 1990))).

335. *See id.* at 446 (“Thus, a custodial relationship created merely by an individual’s voluntary submission to state custody is not a ‘deprivation of liberty’ sufficient to trigger the protections of *Youngberg*.”).

extracted a common theme from other circuits' rulings: whether a state has deprived an individual's liberty and triggered *Youngberg's* protections depends on "whether the individual is free to leave state custody."³³⁶ The court concluded that the petitioners might be able to prove facts supporting that Pennsylvania owed them affirmative duties of care.³³⁷

The Third Circuit ruled that courts should carefully scrutinize the facts in order to determine whether voluntary patients are owed affirmative duties, just as the Eighth Circuit ruled in *Kennedy* and implicitly reaffirmed in *Shelton*.³³⁸ But while *Kennedy* required a factual determination of whether the state's actions had "converted" a voluntary patient into an involuntary patient,³³⁹ the *Torisky* court did not go so far. The Third Circuit's test asks whether the voluntary patient is free to leave.³⁴⁰ Voluntary patients may be restricted from leaving a hospital at will without the state initiating formal commitment proceedings.³⁴¹ The Third Circuit's analysis therefore fits more squarely within *DeShaney's* functional-custody exception.³⁴² Its analysis does not explicitly rely on the voluntary/involuntary

336. *Id.* at 447. The court looked at cases including *Kennedy v. Schafer*, discussed *supra* in section IV.B.2; *Monahan v. Dorchester Counseling Center*, discussed *supra* in section IV.A.2; and *Walton v. Alexander*, discussed *supra* in section IV.A.3.

337. *See id.* at 448 (concluding that "a constitutional violation may have occurred").

338. *See id.* at 447 (stating that the court must look "beyond the label of an individual's confinement"); *Shelton v. Ark. Dep't of Human Servs.*, 677 F.3d 837, 841–42 (8th Cir. 2012) (applying *Kennedy's* rule to the facts in the instant case); *Kennedy v. Schafer*, 71 F.3d 292, 296 (8th Cir. 1995) (remanding the case for a factual determination of Kathleen's status), *cert. denied*, 518 U.S. 1018 (1996).

339. *See supra* notes 303–06 and accompanying text (analyzing *Kennedy's* analysis and ruling).

340. *See Torisky v. Schweiker*, 446 F.3d 438, 447 (3d Cir. 2006) (stating that courts must examine the facts of a patient's custody and determine "whether the individual is free to leave state custody").

341. *See id.* at 446–47 (discussing that patients who voluntarily enter a hospital may face restrictions on their ability to leave, and noting that Pennsylvania law allows a hospital to keep a voluntary patient in custody for up to seventy-two hours).

342. *See id.* at 444 (referencing *DeShaney's* rule that the state owes affirmative duties to individuals over whom it exercises functional custody).

distinction but the court's inquiries overlap with *Kennedy's* de facto involuntary commitment analysis.

V. Concerns about Overreliance on Voluntary/Involuntary Distinction

Given the division among circuits over what analytic method courts should use to determine whether voluntary patients are owed affirmative duties, this Part suggests that an analysis putting less emphasis on voluntary status is appropriate. Categorizing patients as either voluntary or involuntary is easy, but often fails to accurately and reliably capture the full picture of a patient's relationship with the state.³⁴³ This Part considers two reasons that a patient's voluntary status may not accurately describe his relationship to the state: competency and coercion.

A. Competency: Can Acutely Mentally Ill Patients Give Informed Consent?

Voluntary admission requires that an individual express his agreement to be hospitalized by giving informed consent.³⁴⁴ Unless a court has determined that an individual is incompetent, the law presumes that a person can make personal decisions regarding medical treatment.³⁴⁵ Competency raises special issues in the setting of a psychiatric hospitalization.³⁴⁶

When a person is acutely ill with a psychiatric illness—to the point of requiring inpatient care—is that person competent to give informed consent? For most of the twentieth century, all

343. The concurrence in *Walton v. Alexander*, 44 F.3d 1297, 1309–10 (5th Cir. 1995) (Parker, J., concurring), highlighted the problem with substituting voluntary status for a more thorough analysis of the facts.

344. See Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 HOUS. L. REV. 15, 15–16 (1991) (explaining that informed consent requires: informational disclosure; competency; voluntariness; and a decision).

345. See *id.* at 21–22 (discussing the presumption that adults are legally competent).

346. See *id.* at 18 (“[C]ompetency is one of the central questions of mental health law.”).

patients were hospitalized involuntarily, and courts believed that patients' severe psychiatric symptoms rendered them per se incompetent.³⁴⁷ The Supreme Court voiced concerns about competence and voluntary consent in *Zinermon v. Burch*.³⁴⁸ In that case, a voluntary patient challenged his admission status, arguing that he had lacked the capacity to give informed consent when he signed his voluntary admission paperwork.³⁴⁹ The Court agreed with the patient, reasoning that mental illness, by its very nature, "create[s] special problems regarding informed consent," meaning that hospital staff may not be justified in accepting a patient's proffered consent for treatment "at face value."³⁵⁰

Generally, competence to make treatment decisions hinges on whether a patient can make rational decisions about his treatment or whether he can care for himself.³⁵¹ Making these competency determinations imposes considerable burdens on clinicians and healthcare facilities.³⁵² Finding a patient incompetent often requires clinicians to follow extra procedures in the course of providing treatment, because a surrogate decision maker may now make the patient's decisions.³⁵³ Patients requiring psychiatric hospitalization may be legally incompetent because of their acute symptoms, but may nevertheless be treated as competent and permitted to sign the paperwork for voluntary admission.³⁵⁴

347. See, e.g., *Sporza v. German Sav. Bank*, 84 N.E. 406, 408 (N.Y. 1908) (describing the state's history of institutionalizing people adjudicated insane "on account of the necessity of protecting them and the public from their disordered minds and insane acts").

348. See *Zinermon v. Burch*, 494 U.S. 113, 138–39 (1990) (affirming that petitioner stated a claim for relief in alleging that Florida violated his procedural due process rights by admitting him as a voluntary patient, when petitioner alleged he was incompetent to give consent at the time of signing the admission paperwork).

349. *Id.*

350. *Id.* at 133 n.18.

351. See JOHN PARRY, *CIVIL MENTAL DISABILITY LAW, EVIDENCE AND TESTIMONY* 147–49 (2010) (reviewing standards for determining competence to make treatment decisions).

352. *Id.* at 143.

353. *Id.*

354. See *id.* (stating that in order to ensure a patient receives a fair competency determination, the patient should have a lawyer and access to a

In such a situation, the patient's "voluntary" label threatens to mislead a court relying on the voluntary/involuntary distinction as a proxy for understanding the relationship between a patient and the state. The fact that a patient was voluntarily admitted means little when the admission was flawed.³⁵⁵ As the Supreme Court pointed out in *Zinermon*, a legally incompetent "voluntary" patient may very well be "unlikely to benefit from the voluntary patient's statutory right to request discharge."³⁵⁶

B. Coercion: How do External Forces Influence a Patient's Voluntary Status?

Related to capacity and informed consent are concerns that outside forces—such as professionals, family members, the legal system, or mental health policies—influence a patient's status as voluntary or involuntary.

Apprehensions about clinical staff coercing patients have influenced mental health policies since the 1960s.³⁵⁷ As discussed

medical expert).

355. See Karna Halverson, *Voluntary Admission and Treatment of Incompetent Persons with a Mental Illness*, 32 WM. MITCHELL L. REV. 161, 166 (2005) (arguing that "allowing the patient to be voluntarily admitted based on his or her consent without any competency determination leaves too much room for abuse"); Albert B. Palmer & Julian Wohl, *Voluntary Admission Forms: Does the Patient Know What He's Signing?*, 23 HOSP. & COMMUNITY PSYCH. 38, 38 (1972) (presenting results from a study, which indicated that only one of forty patients could recount the essential provisions of a signed voluntary admission form); Donald H. Stone, *The Benefits of Voluntary Inpatient Psychiatric Hospitalization: Myth or Reality?*, 9 B.U. PUB. INT. L.J. 25, 26 (1999) ("Voluntary psychiatric hospitalization should be the result of a competent and informed decision arrived at within a non-coercive environment. Hospitalization based on anything less is not only involuntary, but it is an infringement of personal liberty."); *id.* at 36 ("[O]ften a mentally ill person, upon arrival at a psychiatric hospital, is disoriented or distressed. Because the patients are disturbed, confused, frightened, and distraught, there are indications that they are unable to comprehend the major step they take through self-admission.").

356. *Zinermon v. Burch*, 494 U.S. 113, 133 (1990).

357. See PARRY, *supra* note 351, at 467 (discussing concerns that patients were coerced to accept voluntary hospitalization and care). Beyond questions of coercion in the admission process are questions about coercion in treatment. See MORRIS, *supra* note 176, at 171 (stating that professionals have long debated whether involuntarily committed individuals may refuse treatment). In general,

above, voluntary hospitalization became increasingly popular among legal and psychiatric professionals in the last century, and an increasing proportion of patients consented to voluntary admission during this same period.³⁵⁸ Similarly, as state-hospital professionals returned to preferring involuntary admissions, more state-hospital patients are being involuntarily admitted.³⁵⁹

This power to influence patients' decisions blurs the line dividing voluntary and involuntary patients. For example, the Supreme Court noted that if a voluntary patient is actually incapable of making informed decisions, this patient probably is not in a position to exercise his legal rights.³⁶⁰ The hospital setting increases the risk that patients' decisions will be unduly influenced.³⁶¹ Psychiatric clinicians treating acutely ill patients approach issues like coercion differently than do constitutional scholars.³⁶² Legal scholars tend to focus on broad principles; clinicians, however, focus more on individual patients and how different actions will affect them.³⁶³ Clinicians' results-based

lawyers have supported the right to refuse in order to prevent a "therapeutic orgy," while mental health professionals have opposed a blanket right in order ensure that patients receive necessary treatment. *Id.*

358. See *supra* notes 164–66 and accompanying text (discussing the movement toward voluntary hospitalization). Several states even enacted laws creating a rebuttable presumption in favor of voluntary admission. See PARRY, *supra* note 351, at 468 (explaining how some states' formal policies favor voluntary hospitalization); *supra* note 167 and accompanying text.

359. See *supra* note 183 and accompanying text (discussing the trend back to civil commitment in state hospitals).

360. See *Zinermon v. Burch*, 494 U.S. 113, 133 (1990) (stating that incompetent patients are "unlikely to benefit from the voluntary patient's statutory right to request discharge").

361. See PARRY, *supra* note 351, at 149 (stating that "the possibility of overreaching and improper influence increases" in inpatient settings).

362. See Robert D. Miller, *The Continuum of Coercion: Constitutional and Clinical Considerations in the Treatment of Mentally Disordered Persons*, 74 DENV. U. L. REV. 1169, 1171–72 (1997) (identifying and discussing multiple reasons that legal scholars and psychiatric clinicians approach issues differently).

363. See *id.* at 1172 (identifying differences between how legal scholars and psychiatric clinicians generally consider issues related to inpatient psychiatric care). Legal scholars tend to assume that clients' wishes should be honored, and they focus narrowly on achieving specific goals, like freedom from restraint. *Id.* In contrast, clinicians focus more broadly on providing effective treatment,

orientation is arguably reasonable; most involuntary patients whose symptoms respond to treatment retrospectively agree that the treatment was in their best interest.³⁶⁴ But aside from arguments about the utility of coerced treatment, the fact remains that coercion is a frequent part of inpatient psychiatric care—even voluntary treatment.³⁶⁵ The “voluntary” label masks coercive elements, giving the impression that any given voluntary patient has fully and competently consented to psychiatric hospitalization.³⁶⁶

Coercion might arise from a variety of sources. The simple threat of involuntary commitment leads some patients to sign voluntary admission forms.³⁶⁷ State law may incentivize patients to avoid involuntary commitment to avoid having a commitment order “on the record.”³⁶⁸ Other patients have described feeling internally coerced by their psychiatric symptoms.³⁶⁹ The legal system’s announced preference for voluntary admissions—as expressed by state statutes, court opinions, policy declarations, and scholars—may play out by encouraging patients to voluntary treatment, but at the expense of enjoying the legal protections springing from involuntary status.³⁷⁰

ensuring that a patient continues engaging in treatment after discharge, and maintaining a safe and therapeutic environment for all patients. *Id.*

364. *See id.* at 1174 (reviewing empirical evidence about patients’ attitudes after receiving effective treatment).

365. *See id.* (stating that the label “voluntary” is at best misleading and, at worst, fraud”).

366. *Id.*

367. *Id.* at 1175; *see also* Petrilá, *supra* note 178, at 393–94 & n.110 (reviewing empirical research indicating that psychiatric patients often consent to hospitalization based on the threat that if they do not consent, they may be civilly committed).

368. *See, e.g.,* MICH. COMP. LAWS § 330.1464a(1) (2012) (“[T]he court shall immediately order the department of state police to enter the [involuntary commitment] order into the law enforcement information network. The department of state police shall remove the court order from the law enforcement information network only upon receipt of a subsequent court order for that removal.”).

369. Miller, *supra* note 362, at 1175.

370. *See* Stone, *supra* note 355, at 27–29

The reasons given for voluntary admission include: (1) it involves less stigma to the patient; (2) it is less coercive; (3) it allows the patient to acknowledge a desire for help and treatment; (4) it respects

Coercion is often indirect. Voluntary patients may be influenced by their fellow patients.³⁷¹ Currently, because state hospitals are admitting a higher proportion of involuntary, dangerous patients, voluntary patients are affected in the hospital's milieu and often receive less clinical attention than their more aggressive peers.³⁷² Moreover, many voluntary patients only agree to hospitalization in the first place because their family or caregiver pressured them to get inpatient treatment.³⁷³

These coercive elements, coupled with uncertainties about capacity, suggest that the voluntary/involuntary distinction cannot validly measure affirmative duties. Coercion and capacity go directly to the nature of the hospitalization.³⁷⁴ The label "voluntary" is an artificial signifier that communicates limited information about whether a patient truly made an informed, intelligent decision to be institutionalized.

individual autonomy; (5) it allows the patient the legal right to request release; (6) it increases patient involvement and personal responsibility; (7) it prevents further deterioration while awaiting the civil commitment hearing; (8) it is less time consuming than a hearing; (9) involuntary admission forces doctor and patient into an adversarial relationship that undermines the therapeutic alliance and adversely affects the patient's participation in treatment; (10) the patient is more likely to succeed; (11) there is a perception that the stay is shorter; (12) the patient who voluntarily undertakes treatment is more likely to be rehabilitated than an involuntary patient; (13) it is normalizing since it is very similar to other medical admissions.

The reasons against voluntary admissions include: (1) the potential for patient abuse exists; (2) the patient is subject to coercion; (3) the patient has fewer opportunities for discharge; (4) the patient is admitted under the threat of involuntary commitment; (5) the patient does not consult an attorney; (6) there is no adversarial process; (7) there is no judicial determination; (8) there is no maximum length of stay; (9) the patient is not free to leave; (10) it is unavailable when the patient is incapable of being in charge.

371. Miller, *supra* note 362, at 1181.

372. *Id.*

373. *See id.* at 1210 (stating that patients' families usually favor treatment).

374. *See id.* (stating that "mentally disordered persons are perhaps subject to more coercion than most other groups" and this coercion often leads to "voluntary" admissions).

VI. *Proposed Analysis for Determining Duties to a Voluntary Patient*

How should courts analyze whether a state-hospital patient was owed affirmative duties of care and protection under substantive due process? This subpart proposes a three-step analysis that avoids the pitfall of overrelying on the voluntary distinction.³⁷⁵

A. *The Proposed Analysis*

Courts should not use a patient's formal voluntary status as a proxy for understanding a patient's relationship to the state. The voluntary/involuntary distinction is unreliable and it unduly constrains the analysis.³⁷⁶ So how can courts determine which voluntary patients are owed *Youngberg* duties and which are not?

DeShaney itself suggests a straightforward approach. Starting with the general no-duty rule, *DeShaney* then offered three exceptions, each triggering affirmative duties: formal custody, functional custody, and state-created danger.³⁷⁷ This translates cleanly into a three-part test that considers whether any of these exceptions apply when a plaintiff alleges that a State violated an affirmative duty.³⁷⁸

In the state hospital context, this three-part test provides courts with a logical method for analyzing affirmative duties. When a patient sues the State based on a claim that the state failed to provide an affirmative duty of care or protection, the court should begin with the general rule that no duty exists.³⁷⁹

375. *Infra* Part VI.A.

376. *See supra* Part V (arguing that the voluntary distinction fails as a screening tool).

377. *See supra* Part II.B.2 (analyzing *DeShaney*).

378. *See* Higgs v. Latham, No. 91-5273, 1991 WL 216464, at *6 (6th Cir. Oct. 24, 1991) (per curiam) (Suhrheinrich, J., concurring) (arguing that the court should “go beyond asking whether [the patient] was a voluntary admittee” and consider whether the state-created danger or functional custody exceptions apply).

379. *See supra* Part II.A (discussing the general no-duty rule in substantive due process).

Before addressing any qualified immunity arguments, the court should determine whether the plaintiff has established that he was owed affirmative duties at the time of injury.³⁸⁰ Next, the court should determine whether one of three exceptions apply.

First, affirmative duties arise if the state civilly commits the patient, taking formal custody.³⁸¹ Patients with a formal “involuntary” status, like Mr. Romeo,³⁸² fall into this exception. The voluntary/involuntary distinction is used as a screening tool for this exception, sorting out which patients are in the state’s formal custody. The distinction does not mean that involuntary status is the *source* of the affirmative duties, only that involuntary patients meet the *standard* for acquiring affirmative duties, as decided in *Youngberg*.

Second, affirmative duties arise if the state acts to take functional custody over a voluntary patient.³⁸³ In this analysis, the court may look to state actions that potentially converted the voluntary hospitalization into a de facto involuntary one. For example, courts might find functional custody if the facts show that: the patient lacked capacity at the time he signed voluntary paperwork; staff coerced the patient to sign voluntary paperwork; the patient requested to be discharged and staff declined this request; or the staff exercised an extremely high degree of control over the patient, with the effect of excluding other people from helping the patient. In *Higgs*, for example, the fact that Mrs. Higgs was under a court order for inpatient care and that her requests to be discharged were denied could create an affirmative duty.³⁸⁴ By contrast, the functional custody exception should fail in *Monahan* unless Mr. Monahan could show that he was coerced to remain in the state’s care.³⁸⁵

380. See *Cnty. of Sacramento v. Lewis*, 523 U.S. 833, 841 n.5 (1998) (stating that courts should determine whether a plaintiff was owed a constitutional duty before reaching qualified immunity arguments).

381. See *supra* Part II.B.1 (discussing *Youngberg*’s rule that involuntary commitment triggers affirmative duties).

382. See *supra* Part II.B.1 (discussing *Youngberg*).

383. See *supra* Part II.C.1 (discussing the functional custody exception).

384. See *supra* Part IV.A.1 (discussing *Higgs*).

385. See *supra* Part IV.A.2 (discussing *Monahan*).

Third, affirmative duties arise if the state created or increased the danger that caused the patient's harm.³⁸⁶ Courts again should apply the standards developed within their own circuits for state-created danger.³⁸⁷ State-created danger may be found if the plaintiff can show that: the state had documented awareness either that the patient was substantially at risk to injure himself or be injured by another person; the staff cut off other sources of aid, such as limiting visitors' access or not informing family about the patient's risk; and the state, by a direct action or policy, increased the likelihood that the patient would suffer the foreseen harm. If another patient inflicted the injury, courts should scrutinize whether the hospital reasonably should have known that the wrongdoer might commit this harm. State-created danger might apply in *Shelton*, given that Brenda was an inpatient, cut off from any other sources of aid, and hospital staff refused to administer resuscitation—although this outcome is less clear.³⁸⁸ *Kennedy* presents a clearer case of state-created danger because staff—aware that Kathleen presented such a serious risk of suicide that she required constant staff presence—failed to follow these ordered precautions.³⁸⁹ The state hospital cannot become a “snake pit” without the state acquiring affirmative duties.³⁹⁰

B. Benefits of this Approach

The Proposed Analysis offers a straightforward application of *DeShaney* and *Youngberg*, nudging courts to look beyond voluntary/involuntary issues. This subpart explains three benefits from this analysis: it considers the voluntary/involuntary

386. See *supra* Part II.C.2 (discussing the state-created danger exception).

387. See *supra* note 136 and accompanying text (reviewing state-created danger tests).

388. See *supra* Part IV.B.2 (discussing *Shelton*).

389. See *supra* Part IV.B.2 (discussing *Kennedy*).

390. See *Bowers v. DeVito*, 686 F.2d 616, 618 (7th Cir. 1982) (analogizing the state-created danger scenario to the government throwing a man into a snake pit).

distinction appropriately, it comports squarely with substantive due process doctrine, and it does not unduly burden states.³⁹¹

1. The Proposed Analysis Appropriately Considers the Voluntary Distinction

A primary benefit of the proposed analysis is that it accords the voluntary distinction appropriate weight. The voluntary/involuntary distinction determines whether the formal custody exception applies. Civilly committed patients fall clearly within *Youngberg* and their affirmative rights are clearly established.³⁹²

For voluntary patients, however, the analysis limits the importance of the voluntary/involuntary distinction. Consistent with most circuits, the analysis rejects the idea that all voluntary patients have *Youngberg* rights.³⁹³ But the analysis also rejects the idea that formal commitment procedures are required.³⁹⁴ Instead, the analysis directs courts to apply the functional custody and state-created danger exceptions. Circuits cultivated these doctrines in the years since *DeShaney*, and there is no reason that courts cannot apply these tests in state hospital contexts.³⁹⁵

391. See *infra* Parts VI.B.1–3 (discussing each benefit in turn).

392. See *supra* note 67 and accompanying text (explaining *Youngberg*'s rule).

393. See, e.g., *Torisky v. Schweiker*, 446 F.3d 438, 446 (3d Cir. 2006) (“[A] custodial relationship created merely by an individual’s voluntary submission to state custody is not a ‘deprivation of liberty’ sufficient to trigger the protections of *Youngberg*.”).

394. See *id.* (rejecting the argument that “a court commitment to state custody is a necessary characteristic of a deprivation of liberty sufficient to trigger *Youngberg*”).

395. See *Walton v. Alexander*, 44 F.3d 1297, 1309 (5th Cir. 1995) (Parker, J., concurring) (“Rather than simply asking whether a person entered state custody ‘voluntarily,’ we should examine the nature of the custodial relationship that existed between the State and the plaintiff.”); *Higgs v. Latham*, No. 91-5273, 1991 WL 216464, at *6 (6th Cir. Oct. 24, 1991) (per curiam) (Suhrheinrich, J., concurring) (arguing that courts should “go beyond asking whether [the patient] was a voluntary admittee” and consider whether the state-created danger or functional custody exceptions apply).

The proposed analysis protects voluntary patients' rights. Psychiatric patients—both voluntary and involuntary—face barriers to vindicating their legal rights.³⁹⁶ And the patients labeled “voluntary” may be even more vulnerable, given that their admissions may be tainted by coercion or flawed consent.³⁹⁷ The analysis recognizes this vulnerability and allows courts some discretion in ruling on a particular set of facts. This discretion is fitting. Substantive due process

formulates a concept less rigid and more fluid than those envisaged in other [constitutional provisions]. Its application is less a matter of rule. Asserted denial is to be tested by an appraisal of the totality of facts in a given case. That which may, in one setting, constitute a denial of fundamental fairness, shocking to the universal sense of justice, may, in other circumstances, and in the light of other considerations, fall short of such denial.³⁹⁸

Tests relying on the voluntary distinction constrain courts by obstructing their ability to find affirmative duties in specific cases.

Giving courts more flexibility to find affirmative duties to voluntary patients furthers the goals of § 1983. Section 1983 should not “supplant traditional tort law,”³⁹⁹ but neither should § 1983 claims be rendered useless. As the Supreme Court explained in *Monroe v. Pape*,⁴⁰⁰ § 1983 claims should

396. See *Wyatt v. Aderholt*, 503 F.2d 1305, 1316 (5th Cir. 1974)

Mental patients are particularly unlikely to be aware of their legal rights. They are likely to have especially limited access to legal assistance. Individual suits may be protracted and expensive, and individual mental patients may therefore be deterred from bringing them. And individual suits may produce distortive therapeutic effects within an institution, since a staff may tend to give especially good—or especially harsh—treatment to patients the staff expects or knows to be litigious.

397. See *supra* Part V (discussing how issues related to competence and coercion may render a formal voluntary admission status misleading).

398. *Betts v. Brady*, 316 U.S. 455, 462 (1942), *overruled on other grounds by Gideon v. Wainwright*, 372 U.S. 335 (1963).

399. *Daniels v. Williams*, 474 U.S. 327, 332 (1986).

400. *Monroe v. Pape*, 365 U.S. 167 (1961) *rev'd in part*, *Monell v. Dep't of Soc. Servs.*, 436 U.S. 658 (1978).

supplement state law claims.⁴⁰¹ If a voluntary patient makes out sufficient facts to convince the court that the state owed him affirmative duties, he must be able to enforce this right.⁴⁰²

Moreover, § 1983's remedies—the injunction and litigation costs, specifically—are powerful and important tools for prompting institutional reform in state hospitals.⁴⁰³ As state hospitals evolve by closing down beds, admitting more criminal defendants, and treating more dangerous and more seriously ill patients,⁴⁰⁴ § 1983 should retain its power as a sword. The Supreme Court recently indicated that courts cannot limit the injunction's potency by denying this relief to a broad class of people.⁴⁰⁵ The analysis offers voluntary patients the chance to persuade a court to use this sword.

2. *The Proposed Analysis Retains Doctrinal Integrity*

The proposed analysis is also faithful to existing law. First, with regard to substantive due process, doctrinal integrity is imperative because substantive due process is vulnerable to

401. See *id.* at 171 (concluding that Congress intended for the Act to “give a remedy to parties deprived of constitutional rights”). After reviewing legislative history, the Court found that Congress planned for the Act to serve three purposes: to override invidious state laws, to provide remedy when state law insufficiently protected rights, and to provide additional remedies when state remedies were inadequate or impractical. *Id.* at 173–74.

402. See *Marbury v. Madison*, 5 U.S. 137, 163 (1803) (“The very essence of civil liberty certainly consists in the right of every individual to claim the protection of the laws.”).

403. See, e.g., *United States v. Tennessee*, 615 F.3d 646, 648 (6th Cir. 2010) (refusing to vacate outstanding orders stemming from a district court’s original 1993 injunction against a state hospital that was violating patients’ substantive due process rights); *Thomas v. Flaherty*, 902 F.2d 250, 251–52 (4th Cir. 1990) (upholding a district court’s order for injunctive relief for a class of patients whose constitutional rights were violated by the “deficient care” in state hospitals).

404. See *supra* Part III.B (discussing changes in state hospitals since the 1950s).

405. See *eBay v. MercExchange, L.L.C.*, 547 U.S. 388, 393 (2006) (rejecting “expansive principles suggesting that injunctive relief could not issue in a broad swath of cases”).

confusion and misapplication.⁴⁰⁶ Courts frequently approach claims purporting to potentially expand individual rights with “wariness and even embarrassment.”⁴⁰⁷ By deriving its analysis directly from *DeShaney*, the analysis avoids arbitrarily expanding substantive due process’s protections. After focusing courts’ attention through *DeShaney*’s lens, the analysis points to specific factors relevant to state hospitals. For example, questions about coercion and competence raise significant concerns in state hospitals, but are probably irrelevant in contexts lacking any potential for the victim to “consent to” the state’s control. The analysis captures a clear picture of a patient’s relationship to the state, rather than a mere glimpse of voluntary status.

Second, the proposed analysis is more consistent with legal doctrine related to custody than are the status-driven approaches some circuits currently apply. While the Supreme Court has not addressed whether voluntary patients are “in custody,” it has offered guidance on this question in the Fourth Amendment context.⁴⁰⁸ Custody assessments—at least for Fourth Amendment purposes—require courts to approach the situation from the individual’s point of view, not the state’s.⁴⁰⁹ How do these rules relate to custody for substantive due process purposes? The Sixth Circuit argued that in the context of voluntary patients, custody claims under the Fourth and Fourteenth Amendments should be treated identically.⁴¹⁰ The Third Circuit similarly ruled in *Torisky* that affirmative duties must depend on whether the patient is free to leave.⁴¹¹ Because custody turns on the individual’s objective perspective, in state hospitals, a patient’s *legal*

406. See Richard H. Fallon, *Some Confusions about Due Process, Judicial Review, and Constitutional Remedies*, 93 COLUM. L. REV. 309, 309 (1993) (“Due process doctrine subsists in confusion.”).

407. *Id.*

408. See *Stansbury v. California*, 511 U.S. 318, 323 (1994) (per curiam) (stating that whether or not a person is “in custody” depends on the perspective of a reasonable person in the suspect’s position).

409. *Id.*

410. See *Lanman v. Hinson*, 529 F.3d 673, 683 (6th Cir. 2008) (“Differentiating Fourteenth Amendment cases from . . . Fourth Amendment [cases] based on the voluntary or involuntary nature of the state’s custody would lead to arguably inconsistent results.”).

411. See *supra* note 337 (giving *Torisky*’s ruling).

voluntary status should not be conflated with his *reasonably perceived* status. If a voluntary patient reasonably believes that he has no right to leave, his “voluntary” label means little.

Third, the proposed analysis offers courts a coherent framework for analysis. This point is highlighted by *Kennedy*. In that case, the Eighth Circuit found affirmative duties by determining that Kathleen, while formally a voluntary patient, may have been constructively involuntary.⁴¹² By stretching the category of “involuntary” patients in this way, the decision unnecessarily muddies the law. The court’s rationale that “[f]acts change, and legal status follows facts,”⁴¹³ would suggest that if the facts of *Kennedy* remained the same, but Kathleen had not killed herself, she nevertheless would have been involuntary—but without any of the due process protections afforded by the civil commitment process. *Zinermon* directly prohibits such a result.⁴¹⁴ The *Kennedy* court’s analysis comports more squarely within the proposed analysis, allowing it to neatly find affirmative duties arising from state-created danger, rather than stretching the voluntary/involuntary distinction beyond its fibers.

3. *The Proposed Analysis Will Not Unduly Expand Affirmative Duties*

Allowing some voluntary patients *Youngberg* rights is unlikely to produce intolerable policy results. States frequently assert that imposing liability will force unsustainably weighty burdens on them and cause a disastrous fallout.⁴¹⁵ These concerns should be viewed with a critical eye. For example, some advocates charge that states will stop admitting voluntary

412. *Kennedy v. Shafer*, 71 F.3d 1522, 295 (8th Cir. 1995), *cert. denied*, 518 U.S. 1018 (1996).

413. *Id.* at 296.

414. *Zinermon v. Burch*, 494 U.S. 113, 138–39 (1990) (ruling that voluntary admission proceedings cannot substitute for involuntary commitment).

415. *See, e.g.*, Petition for Writ of Certiorari at 16, *Schafer v. Kennedy*, No. 95-1697, 1996 WL 33439744, at *16 (Apr. 19, 1996) (arguing that the Eighth Circuit’s ruling that a de facto involuntary patient is owed affirmative duties incentivizes states “to deny care to the mentally ill”), *cert. denied*, 518 U.S. 1018 (1996).

patients altogether because the risk of liability “is too great to jeopardize” state resources.⁴¹⁶ Aware that current “voluntary” patients might be relabeled “involuntary” by some court in the future, the argument goes, hospital staff will be left unsure whether they owe affirmative duties.⁴¹⁷

To be sure, increasing potential liability in state hospitals will produce corollary burdens. Underfunded state mental health systems may be forced to spend their tight budgets on legal fees and judgments.⁴¹⁸ State hospital workers would also face increased exposure to personal liability, and may be unable to obtain insurance coverage for constitutional violations.⁴¹⁹

When considered in light of the current state hospital system,⁴²⁰ however, these concerns appear overblown. First, it seems implausible that states will stop admitting and treating voluntary patients. History belies such an argument. *Youngberg* explicitly granted affirmative duties to every involuntary patient, but states did not react by refusing to treat involuntary patients, a decision that would have been within states’ discretion.⁴²¹ Why would a different result follow if some voluntary patients are granted affirmative rights? Hypothetically, if states did react by shutting their doors to voluntary patients, then they would correspondingly open their doors to more involuntary patients.⁴²² The result would be that every patient would possess affirmative *Youngberg* rights.⁴²³ Allowing voluntary patients to establish

416. *Id.*

417. *Id.* at *16–17.

418. *See id.* at *17–19 (arguing that state budgets will suffer potentially untenable consequences if voluntary patients are found to have affirmative rights).

419. *See* APPELBAUM & GUTHEIL, *supra* note 46, at 138 (discussing due process claims against individual clinicians).

420. *See supra* Part III.B (discussing how state hospitals evolved in recent decades).

421. *See supra* Part II.B.1 (discussing *Youngberg*); *see also supra* note 183 and accompanying text (noting that state hospitals are trending toward involuntary patients).

422. *See* SAMHSA FUNDING REPORT, *supra* note 175, at 69–70 (stating that many states currently face a shortage of state hospital beds).

423. *See Youngberg v. Romeo*, 457 U.S. 307, 316–17 (1982) (ruling that states owe affirmative duties under substantive due process to involuntarily committed individuals).

affirmative constitutional rights, then, should not be precluded out of concerns for state budgets.

Second, state actors are protected by the deferential professional judgment standard for imposing liability.⁴²⁴ The professional judgment standard is more deferential than the “reasonable care” standard in malpractice claims.⁴²⁵ The reasonable care standard imposes liability if a defendant’s conduct deviates at all from what a reasonable professional would do; the professional judgment standard imposes liability only for a substantial deviation.⁴²⁶ The Supreme Court chose this standard in *Youngberg* to avoid overly burdening states.⁴²⁷ The Court reasoned that the professional judgment standard protects hospitals and individual clinicians by relieving them of a burden “to make each decision in the shadow of an action for damages.”⁴²⁸ With this standard’s protections, state actors will be insulated from an uncontrolled new wave of liability.

VII. Conclusions

The government owes us nothing. *DeShaney* highlighted this general principle with its unrelentingly formal analysis of a shockingly tragic case.⁴²⁹ And *DeShaney*’s message has been received in lower courts.⁴³⁰

424. See *id.* at 324 (“In determining whether the State has met its obligations . . . decisions made by the appropriate professional are entitled to a presumption of correctness.”).

425. See PARRY, *supra* note 351, at 652 (discussing both standards).

426. *Id.*

427. See *Youngberg*, 457 U.S. at 324 (“Such a presumption is necessary to enable institutions of this type—often, overcrowded and understaffed—to continue to function.”).

428. *Id.* at 325.

429. See *supra* Parts II.A, II.B.2 (discussing the no-duty rule and *DeShaney*).

430. See SCHWARTZ, *supra* note 5, § 3.09[B] (“*DeShaney* has generated an unusually large volume of important lower federal court rulings.”); see also *Doe v. Milwaukee Cnty.*, 712 F. Supp. 1370, 1371 (W.D. Wis. 1989) (“Joshua DeShaney will never know it, unfortunately, but he has had a dramatic impact on constitutional law. The case that grew out of a tragedy . . . is already affecting law suits across the country.”).

But amidst this post-*DeShaney* storm, courts must not overlook the exceptional cases. Sometimes the government does owe a duty to protect or care for individuals.⁴³¹ State hospitals present a complicated context for evaluating when affirmative duties apply, and state-hospital patients are particularly vulnerable.⁴³² A patient's relationship with the state is more complicated than his voluntary status. Courts falter when they conflate a patient's voluntary status—either formal or de facto—with a sound legal test for affirmative duties.

Voluntary status should not preclude affirmative duties. Courts should have some modicum of discretion to provide a just ruling in the case at hand.⁴³³ The proposed analysis suggested in this Note offers a flexible standard without sacrificing doctrinal integrity.⁴³⁴

Stepping back and reflecting on *DeShaney* and its wake, it's almost surprising to remember that some of the most important facts remain a mystery. Wisconsin never explained *why* it chose not to intervene to protect little Joshua, even as the social worker dutifully chronicled her suspicions “in detail that seems almost eerie.”⁴³⁵ No explanation was required once the Court found that no duty existed.⁴³⁶

But *DeShaney* explicitly demanded that sometimes an explanation is needed. Sometimes state actors should be called upon to explain their decisions. In cases involving state-hospital patients, courts should not gloss over the special issues that may

431. See *supra* Parts II.B.1, II.C.1–2 (discussing *Youngberg*, the functional custody exception, and the state-created danger exception).

432. See *supra* Parts III, V (reviewing mental health law and the nature of state hospitals).

433. See, e.g., BENJAMIN CARDOZO, *THE NATURE OF THE JUDICIAL PROCESS* 66 (1921)

There is an old legend that on one occasion God prayed, and his prayer was “Be it my will that my justice be ruled by my mercy.” That is a prayer which we all need to utter at times when the demon of formalism tempts the intellect with the lure of scientific order.

434. See *supra* Part VI (containing the proposed analysis and arguing its strengths).

435. *DeShaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 209 (1989) (Brennan, J., dissenting).

436. *Id.*

arise. Courts should ask whether the state created a duty, whether by civilly committing a patient, by exercising functional custody, or by creating a danger. When the government takes those actions against us, then it does owe us something.