From Opt-In to Opt-Out: Legal Representation in Involuntary Hospitalization in Israel and the United States

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Abstract: Involuntary hospitalization of individuals with mental health disorders raises legal and ethical issues, particularly concerning the balance between the right to due process and patient autonomy, and the need to ensure optimal care while preventing harm. In Israel, the right to legal representation in involuntary hospitalization proceedings aims to mitigate the infringement on patients' rights. This Article examines the current Opt-In model of legal representation in some U.S. states and presents the advantages of the Opt-Out model in Israel, in which representation is provided by default, preserving the patient's right to refuse. Findings from a unique empirical study indicate that the Opt-Out model increases access to legal representation and enhances procedural fairness. The Article also compares various legal approaches by examining models implemented in the U.S. It offers practical recommendations for adopting the Opt-Out model in Israel and U.S. states in which the Opt-Out model is implemented. It proposes oversight mechanisms to ensure informed decision-making and points out the importance of balancing patients' rights and the need to safeguard their health and well-being.

I. INTRODUCTION

Decision-making regarding the treatment of individuals with mental health disorders, particularly concerning their involuntary hospitalization, involves complex legal and ethical considerations. First, individuals with mental health disorders may lack the full capacity to make independent decisions about their treatment. Second, because of their condition, they may pose a danger to themselves or others. Third, involuntary hospitalization infringes on human rights and the well-being of individuals with mental health disorders. Fourth, involuntary hospitalization fundamentally alters the relationship between caregivers and individuals with mental health disorders because it allows caregivers to restrict or seek judicial approval to restrict the rights of these individuals. Fifth, involuntary hospitalization is based not only on medical considerations for recovery or improvement of their condition but also on the need to prevent harm to themselves or others.

Involuntary hospitalization infringes on personal liberty and freedom of movement. Therefore, involuntary hospitalization necessitates the establishment of standards governing the exercise of government authority in such cases. These standards must be subject not only to internal medical review but also to external judicial oversight. The exercise of government authority must comply with the principles of natural justice, which dictate that before restricting an individual's liberty, they must be granted the right to present their claims.[1] In relevant cases, this right includes legal representation by an attorney. This Article examines the right to legal representation in Israel and the U.S.

The right to legal representation in involuntary hospitalization proceedings, which was first developed in the U.S. in the 1960s and 1970s,[2] is considered one of the most significant tools for protecting the rights of individuals with mental health disorders. In the U.S., key Supreme Court rulings led to significant legislative changes in all states, which adopted the right to safeguard the interests of involuntarily hospitalized individuals.[3] A similar process occurred in Israel when the Mental Health Act was amended

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[1] CrimA 2060/97 Wilenchik v. District Psychiatrist, 52(1) PD 697, 707 (1998) (Isr.).

[2] MICHAEL L. PERLIN & HEATHER ELISS CUCOLO, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL 570 (3d ed. 2017).

[3] *See, e.g.,* O'Connor v. Donaldson, 422 U.S. 563 (1975); Bruce A. Arrigo, *Paternalism, Civil Commitment and Illness Politics: Assessing the Current Debate and Outlining a Future Direction*, 7 J.L. & HEALTH 131 (1992-1993); *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., https://www.govinfo.gov/content/pkg/GOVPUB-HE20_400-PURL-gpo158665/pdf/GOVPUB-HE20_400-PURL-gpo158665.pdf [https://perma.cc/LJ7B-G8VC]; BRUCE A. ARRIGO, PUNISHING THE MENTALLY ILL: A CRITICAL ANALYSIS OF LAW AND PSYCHIATRY 83 (2002).

in 2004, establishing, for the first time, the right to state-funded legal representation for individuals hospitalized involuntarily.[4] This amendment addressed the severe human rights violations associated with involuntary hospitalization and ensured a proper balance between the patients' liberty and the need to protect their health and public safety.[5] This change, however, was met with considerable opposition. Both in Israel[6] and the U.S.,[7] concerns were raised that introducing legal principles into hospitalization procedures might result in excessive "judicialization," potentially undermining the efficiency of the medical process.[8] Some critics focused on the quality of legal representation. They argue that an attorney unfamiliar with the relevant legal field might harm hospitalized individuals rather than assist them.[9] For

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[4] § 5764, Mental Health Act, 2004 (Isr.) ("Amendment No. 5"). This Act is originally in Hebrew and, for purposes of this Article, has been translated to English by the authors with the assistance of a professional language editor. The original Act in Hebrew is on file with the authors.

[5] Abhishek Jain & Paul Appelbaum, *Balancing Autonomy and Beneficence at the Time of Psychiatric Discharge*, 7 ISR. J. HEALTH POL'Y 2, 2 (2018); Uri Aviram & Dan Shnit, *Involuntary Psychiatric Hospitalization and Civil Liberties—The Case of Israel*, in PSYCHIATRY, LAW AND ETHICS 106, 106 (1981).

[6] Josef Assaf Toib, *Challenges for Israeli Mental Health Law in the Next Decade*, 43 ISR. J. PSYCHIATRY & RELATED SCIS. 198, 199 (2006); Uri Aviram & Sagit Azary-Viesel, *Mental Health Reform in Israel: Challenge and Opportunity*, TAUB CTR. FOR SOC. POL'Y STUDIES IN ISR., 5, 27 (2015), https://www.taubcenter.org.il/wp-content/uploads/2015/06/mentalhealthreform english2015.pdf [https://perma.cc/8CND-KMFS].

[7] Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered,* 70 CAL. L. REV. 54, 55 (1982).

[8] Stanley S. Herr, *Human Rights and Mental Disability: Perspectives on Israel*, 26 ISR. L. REV. 142, 170 (1992); William Hoffman Pincus, *Civil Commitment and the Great Confinement Revisited: Straightjacketing Individual Rights*, *Stifling Culture*, 36 WM. & MARY L. REV. 1769, 1789 (1995); Donald A. Treffert*, The Practical Limits of Patients' Rights*, 5 PSYCHIATRIC ANNALS 91, 96 (2013); Paul S. Appelbaum & Thomas G. Gutheil, *Involuntary Mind Control, the Constitution, and the "Right to Rot"*, 137 AM. J. PSYCHIATRY 720, 722 (1980). For a general discussion on the tension between psychiatry and involuntary commitment laws, *see generally* Sheila Wilderman, *Law and Mental Health: A Relationship in Crisis*, 33 DALHOUSIE L.J. 1 (2010) (discussing the tension between psychiatry and involuntary commitment laws); *see also* Ynne Hanson, Renee Fitzpatrick & Shaimaa Abo-El Ella, *Inter-Disciplinary Teaching Strategies for Mental Health Law*, 39 INT'L J. L. & PSYCHIATRY 1 (2015) (noting that under the current legal framework, the result is that people die with their rights intact but without receiving the necessary treatment).

[9] *See generally* Stuart A. Anfang & Paul S. Appelbaum, *Civil Commitment—The American Experience*, 43 ISR. J. PSYCHIATRY & RELATED SCI. 3 (2016) (reviewing the history, legal standards, and policy debates surrounding civil commitment in the United States.; Paul S. Appelbaum, *Almost a Revolution: An International Perspective on the Law of Involuntary Commitment,* 25 J. AM. ACAD. PSYCHIATRY L. 135, 136 (2015); Michael Perlin, *A critical evaluation of the role of counsel in mental disability cases*, 16 LAW & HUM. BEHAV. 39, 43 (1992); Michael L. Perlin, *I Might Need a Good Lawyer, Could be Your Funeral, My Trial: Global Clinical Legal Education and the Right to Counsel in Civil Commitment Cases*, 28 WASH. U. J. L. & POL'Y 241 (2008) (analyzing the role of clinical legal; Michael L. Perlin & Robert L. Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, 45 LAW & CONTEMT. PROBS. 161 (1982) (analyzing ethical

example, by delaying treatment procedures or advocating for premature discharge against the individual's best medical interest.[10]

Given these considerations, this Article examines which legal representation model best protects the rights and interests of involuntarily hospitalized individuals, with an emphasis on preserving their autonomy and health.[11] The Article relies on empirical research conducted by the authors, which demonstrates that legal representation safeguards the rights of involuntarily hospitalized individuals and increases the rates of discharge. In this Article, the contribution of legal representation to the autonomy of involuntarily hospitalized individuals and the assurance of due process is examined by analyzing the functioning of psychiatric boards that review their cases. The research findings indicate that first, legal representation ensures a fair process by allowing the voices of involuntarily hospitalized individuals and their attorneys to be heard, clarifying their wishes, and ensuring that psychiatric boards provide reasoned decisions. And second, legal representation strengthens respect for the autonomy of hospitalized individuals.

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challenges that arise in attorney representation during the civil commitment process); Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases*, 16 LAW & HUM. BEHAV. 39 (1992) (exploring the ethical dilemmas attorneys face when representing individuals subject to involuntary civil commitment); Joshua Cook, *Good Lawyering and Bad Role Models: The Role of Respondent's Counsel in a Civil Commitment Hearing*, 14 GEO. J. LEGAL ETHICS 179, 182 (2000).

[10] *See generally* Elliott Andalman & David L. Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal*, 45 MISS. L.J. 43 (1974) (speculating that counsel was so inadequate in the sample study that patients' chances for hospital release were enhanced if no lawyer was present); George E. Dix, *Acute Psychiatric Hospitalization of the Mentally Ill in the Metropolis: An Empirical Study*, 1968 WASH. U. L. Q. 485 (1968) (noting that only two of 1700 contested cases resulted in patient release). The main conclusions of these studies were that, for an attorney to truly impact the proceedings, they must represent the hospitalized individual with the highest level of effectiveness. This requires the attorney to review the relevant materials, interview family members, and, most importantly, speak with the hospitalized individual prior to the hearing. Due to the significant importance of this practice, several countries have enshrined this obligation in legislation. *See generally* Raven Lidman, *Civil Gideon as a Human Right: Is the U.S. Going to Join Step with the Rest of the Developed World*, 15 TEMP. POL. & CIV. RTS. L. REV. 769 (2006) (arguing that the United States should recognize a civil right to counsel in line with international human rights norms).

[11] *See generally* Alec Buchanan, *Mental capacity, legal competence and consent to treatment,* 97 J. ROYAL SOC'Y MEDI. 415 (2004) (examining the relationship between mental capacity, legal competence, and informed consent in medical treatment decisions); *see generally* Barton W. Palmer & Alexandrea L. Harmell, *Assessment of Healthcare Decision-making Capacity*, 31 ARCHIVES CLINICAL NEUROPSYCHOLOGY 530 (2016) (reviewing conceptual models, assessment instruments, and empirical findings on healthcare decision-making capacity, and offering recommendations for clinical practice) ; *see generally* Jochen Vollmann et al., *Competence of Mentally Ill Patients: a comparative empirical study,* 33 PSYCH. MED. 1463 (2003) (concluding that patients with mental illness are less competent to make decision); *see generally* JASON PAYNE-JAMES et al., MEDICOLEGAL ESSENTIALS IN HEALTHCARE (2d ed. 2004) (showing the various clinical approaches to involuntary hospitalization).

The analysis of the findings and recommendations presented in this Article focuses on the effect of legal representation on the active participation of involuntarily hospitalized individuals in decision-making processes, ensuring their right to due process.[12] The analysis considers the complexity of capacity for decision-making, striving to preserve individual autonomy or, at the very least, to minimize its infringement to the greatest extent possible.[13]

To address these questions, we focus on two primary models of legal representation: the Opt-In Model and the Opt-Out Model. A third model—Mandatory Representation—will be discussed later, but will not be a central focus of this article. Under the Opt-In Model, the right to representation requires the individual with a mental health disorder to actively exercise their right, with the option to waive it. It requires individuals to be aware of their right, understand it, and take proactive steps to exercise it. Under the Opt-Out Model, legal representation is provided by default unless the individual explicitly refuses it. It assumes automatic representation and places the burden of opting out on the individual. After introducing these models, this Article reviews the legal framework in Israel and the U.S. and introduces findings from an extensive field study—the first of its kind in Israel—examining the effect of the right to representation on safeguarding the procedural rights of individuals with mental health disorders. The research findings indicate that legal representation contributes to the protection of hospitalized individuals' rights and ensures a sense of procedural justice, compared with individuals with mental health disorders who were not represented and whose rights were not similarly safeguarded.

The study discusses several proposals to improve the legal representation model in involuntary hospitalization proceedings, based on comparisons with the two models in effect in the U.S. The first one, implemented in Montana, provides legal representation to every involuntarily hospitalized individual

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[12] Paul S. Appelbaum, *A Fool for a Client? Mental Illness and the Right of Self-Representation*, 59 PSYCHIATRIC SERVS. 1096, 1098 (2008). *see generally* Ellesha LeCluyse, *The Spectrum of Competency: Determining a Standard of Competence for Pro Se Representation*, 65 CASE W. RES. L. REV. 1239 (2015) (examining standards of competence for pro se representation).

> [T]he American Psychiatric Association (APA) tells us (without dispute) in its *amicus* brief filed in support of neither party that '[d]isorganized thinking, deficits in sustaining attention and concentration, impaired expressive abilities, anxiety, and other common symptoms of severe mental illnesses can impair the defendant's ability to play the significantly expanded role required for self-representation even if he can play the lesser role of represented defendant.'

Indiana v. Edwards, 544 U.S. 164, 175–76 (2008).

[13] *See generally* sources cited *supra* note 11 (concluding that patients with mental illness are less competent to make decision).

without the possibility of waiving it. This Mandatory Representation model provides absolute protection of hospitalized individuals' right to legal representation, but raises questions concerning individual autonomy. The Opt-Out model, implemented in other states, is based on a more flexible approach where legal representation is provided by default, but hospitalized individuals have the option to waive this right, subject to judicial review assessing their capacity to make an informed and competent decision.

The proposed reforms aim to strike an appropriate balance between protecting the fundamental human rights of individuals who were involuntarily hospitalized, including their right to due process and active participation in decisions affecting their lives, and the need to safeguard their health and safety as well as public security. Adopting a model that combines default legal representation with judicial oversight mechanisms can offer a balanced solution that respects individual rights, ensures procedural justice, and addresses the unique complexities of involuntary hospitalization proceedings. These complexities include, for example, the frequent lack of legal capacity or insight among some patients, the urgency of clinical decisions that must be made under time pressure, the challenges in assessing a person's will and preferences when communication is impaired, and the potential for conflicting interests between the individual, family members, and medical staff.

II. THE RIGHT TO LEGAL REPRESENTATION: LEGAL AND BIOETHICAL CONSIDERATIONS

This chapter begins by outlining the main models of legal representation for individuals with mental health disorders, including Opt-In, Opt-Out, and Mandatory Representation. It then examines the legal foundations of each model, focusing on statutory provisions, constitutional principles, and relevant human rights frameworks. Finally, the chapter evaluates the normative justifications for each approach, providing a basis for assessing which model best protects the right to representation while preserving individual autonomy.

A. The Legal Basis for the Right to Representation

The legal foundation of the right to legal representation in Israel is enshrined in the Bar Association Law.[14] Section 22 of this law establishes that all individuals have the right to consult with and be represented by an

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[14] § 22, Bar Association Act, 5721-1961 (Isr.), https://rotenberglaw.co.il/_Uploads/dbsAttachedFiles/The_Bar_Association_Act_june_2015.pdf [https://perma.cc/U3SQ-BXLB].

attorney to safeguard their rights in dealings with the authorities.[15] Beyond this general provision, specific laws grant an explicit right to legal representation. For example, Section 29A of the Mental Health Act grants involuntarily hospitalized individuals the right to state-funded legal representation before the District Psychiatric Board.[16] Three models are available to ensure the proper implementation of this right: Mandatory Representation, Opt-Out, and Opt-In.

1. Mandatory Representation: Default Representation with No Option to Decline

Under the Mandatory Representation model, the law obligates the state to appoint an attorney to all individuals, regardless of their consent or preference. The validity of the legal process is contingent upon the appointment of legal representation, and individuals cannot waive this right. This model is typically applied in serious criminal proceedings where legal representation is deemed essential for ensuring procedural fairness. For example, Section 15 of the Israeli Criminal Procedure Law mandates legal representation for defendants charged with serious offenses, minors, and individuals with mental or cognitive impairments, even if they do not request representation.[17] In the U.S., Montana applies this model in civil involuntary hospitalization proceedings, ensuring that every individual involuntarily hospitalized has legal representation, which they cannot waive.[18]

Although this model guarantees that all eligible individuals receive legal representation without exception, it arguably constitutes an excessive and disproportionate infringement on personal autonomy. Removing the ability to waive legal representation deprives the individual of maintaining what little control they have over their decision-making. Conversely, an Opt-Out model achieves a high rate of legal representation while simultaneously protecting the autonomy of the hospitalized individual. Consequently, this Article focuses primarily on the comparison between the Opt-In and Opt-Out models, while addressing the Mandatory Representation model to the extent necessary for the analytical and normative discussion.

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[15] *Id.* This provision does not derogate from other statutory provisions regulating representation before state authorities.

[16] § 29, Mental Health Act, 2004 (Isr.).

[17] § 15, Criminal Procedure Law, 5742–1982, LSI 9 184, as amended (Isr.).

[18] *See* MONT. CODE ANN. § 53-21-117 (2023) (providing that a person subject to involuntary commitment has the right to be represented by counsel at every stage of the proceedings); § 53-21-119(1) (2023) (stating that "[t]he right to counsel may not be waived. The right to treatment provided for in this part may not be waived.").

2. Opt-Out Model: Default Representation with the Option to Decline

Under the Opt-Out model, legal representation is provided by default; however, the individual retains the right to waive it, subject to certain conditions. To ensure that such a waiver is made voluntarily and with a full understanding, judicial review may be conducted to assess the individual's competence to make an informed decision about waiving legal representation. This model is common in several U.S. states[19] where involuntarily hospitalized individuals automatically receive legal representation, but they may opt out. In such cases, however, the legal system is required to verify that the individual comprehends the implications of their waiver and is capable of making an informed choice. This model ensures initial legal representation and preserves a degree of individual autonomy.

3. Opt-In Model: Representation Contingent upon Request

Under the Opt-In model, the right to representation is available upon request. The state is required to inform individuals of their right to representation, but no attorney is provided unless the individual explicitly requests one. This model is currently implemented in Israel in civil involuntary hospitalization proceedings.[20] The Mental Health Care Act stipulates that an involuntarily hospitalized individual has the right to legal representation before the District Psychiatric Board, but exercising this right depends on individuals being informed of their rights by the medical facility and choosing to request representation. Individuals must sign a form confirming that they have been informed of their right to legal representation. If they refuse representation, they must sign a waiver form, and the medical facility is required to notify the board accordingly.[21] If they request

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[19] *See infra* Part III for further discussion on the civil involuntary commitment process in the US.

[20] *See* § 29A(e), Mental Health Act, 2004 (Isr.) ("If the patient *requests* to be represented by an attorney under this section, or if the patient's guardian or a relative—where the patient's opinion could not be ascertained—*requests* such representation, the patient shall be given an opportunity to meet with an attorney [to] enable[] proper legal representation." (emphasis added)).

[21] *Id.* The relevant provisions state:

> (a) In proceedings before the Psychiatric Board and in appeals against its decisions, the patient has the right to be represented by an attorney.
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> (b) If the patient is hospitalized under a hospitalization order or is receiving outpatient treatment under a treatment order, they are entitled to be represented in such proceedings, as provided in subsection (a), by an attorney appointed to provide legal services under the Legal Aid Law, 1972.
>
> (c) . . . .

representation, the state provides an attorney.[22] We collectively define these three models as the "Right to Legal Representation."

B. Opt-In vs. Opt-Out Models

As outlined above, the primary forms of implementing the right to legal representation are the Opt-In model (requiring active consent) and the Opt-Out model (assuming consent by default).[23] They represent distinct approaches to how individuals exercise their rights. Whereas the Opt-In model requires a proactive move on the part of the individual, the Opt-Out model assumes automatic entitlement to a right unless the individual explicitly opts out.

Following the Opt-In model, as applied in Israel under the Mental Health Care Act, individuals are informed of their rights but must initiate the process of obtaining legal counsel.[24] This approach reflects the importance of informed decision-making and personal autonomy. The primary advantage

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> (d) The director [of a hospital designated for the hospitalization of individuals with mental health disorders or a psychiatric department in a general hospital] [. . .] shall inform the patient, and if they have a guardian, also their guardian, as soon as possible upon hospitalization, of their right to legal representation [. . .]; if the patient's opinion on the matter cannot be ascertained due to their medical condition and they do not have a guardian, the notice shall be given to one of the patient's relatives. If the patient requests legal representation under this section, or if their guardian or a relative of a patient whose opinion cannot be ascertained requests legal representation, the patient shall be given an opportunity to meet with an attorney in a manner that allows for adequate representation.

Details regarding the right to representation, its implementation, and waiver thereof are established in the Treatment for Persons with Mental Disabilities (Legal Representation in Involuntary Treatment) Regulations, 5766-2006 [hereinafter *Legal Representation Regulations*].

[22] *Id.*

[23] *See generally* Joseph W. Sakshaug, et al., *Evaluating Active (Opt-In) and Passive (Opt-Out) Consent Bias in the Transfer of Federal Contact Data to a Third-Party Survey Agency*, 4 J. SURV. STAT. & METHODOLOGY 382 (2016) (studying the efficacy of opt-in versus opt-out methods of surveys); James R. Jolin, *How to Construct Better Organ Donation Policy and Achieve Health Equity*, BILL OF HEALTH (Apr. 21, 2022), https://petrieflom.law.harvard.edu/2022/04/21/how-to-construct-better-organ-donation-policy-and-achieve-health-equity [https://perma.cc/8KYL-JEDD] (discussing the advantages and disadvantages of opt-out organ donation); Usman Ahmad, et al., *A Systematic Review of Opt-Out Versus Opt-In Consent on Deceased Organ Donation and Transplantation (2006–2016)*, 43 WORLD J. SURGERY 3161 (2019) (finding that an opt-out consent model to organ donation decreases deaths in those waiting for transplant).

[24] Section 3 of the *Legal Representation Regulations* stipulates that immediately after hospitalization, the patient must be informed of their right to legal representation. Section 5 states that if the patient requests representation, it must be provided. Thus, the right to representation is contingent upon the patient's request. *Legal Representation Regulation*, *supra* note 21 § 3, 5.

of the Opt-In model lies in its assurance that the right is exercised based on an explicit and conscious decision. When an individual requests representation, we can assume that the decision was made with awareness of the right and its consequences. This model reinforces individuals' sense of control over their decisions, particularly in sensitive matters such as legal representation in involuntary hospitalization proceedings, because the individual must understand the right and its importance before they can act upon it.[25]

At the same time, the emphasis on proactive action presents challenges for vulnerable populations, such as involuntarily hospitalized individuals with mental health disorders. These individuals may face cognitive, psychological, or physical limitations that hinder their ability to process information, evaluate options, and request legal representation explicitly. As a result, some individuals fail to exercise their right to representation, even in cases where it is crucial for protecting their legal interests. Moreover, in certain cases, individuals may waive their rights without fully grasping the implications of their decision, potentially compromising their procedural rights and access to justice.

The Opt-Out model offers a different approach, where representation is the default, and individuals must actively decline it. This approach simplifies the process and ensures broader access to legal representation. Behavioral research suggests that the Opt-Out model leverages the "default bias," a cognitive tendency where individuals are more likely to stay with preset options.[26] As a result, the Opt-Out model significantly increases the exercise of rights.[27]

The Opt-Out model has proven effective in various domains, such as organ donation. Countries that implement an Opt-Out system for organ donation have substantially higher participation rates than those requiring

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[25] Harriet R. Etheredge, *Assessing Global Organ Donation Policies: Opt-In vs Opt-Out*, 14 RISK MGMT. & HEALTHCARE POL'Y 1985, 1985–98 (2021); Haoyang Yan & J. Frank Yates, *Improving Acceptability of Nudges: Learning from Attitudes Towards Opt-In and Opt-Out Policies*, 14 JUDGMENT & DECISION MAKING 26, 26–39 (2019) (finding that opt-in approaches are perceived as more ethical and respectful of autonomy than opt-out approaches, particularly in contexts involving sensitive personal decisions).

[26] *See* Lauren E. Willis, *Why Not Privacy by Default?,* 29 BERKELEY TECH. L.J. 61 (2014). The author discusses the default settings on websites, which allow service providers to track users' data. While users can opt out of such tracking, doing so requires an active step and sometimes incurs "penalties," such as restricted access to certain applications. Consequently, many users refrain from selecting the Opt-Out option. *See also* Ian Ayres, *Regulating Opt-Out: An Economic Theory of Altering Rules*, 121 YALE L.J. 2032 (2012).

[27] Thomas C. Leonard, Richard H. Thaler & Cass R. Sunstein, *Nudge: Improving Decisions About Health, Wealth, and Happiness,* 19 CONST. POL. ECON., 356, 356–60 (2008).

explicit consent.[28] The underlying premise is that default options enable most individuals to exercise rights or agree to procedures they may not have actively chosen but, at the same time, do not fundamentally oppose.[29] In the case of legal representation, the Opt-Out model may be particularly beneficial for involuntarily hospitalized individuals, who may struggle with the procedural demands of an Opt-In system. A default legal representation mechanism ensures the broad realization of this right and minimizes the risk of procedural injustice.

The effectiveness of Opt-Out frameworks in other domains further illustrates the power of default settings in shaping behavior. In the context of organ donation, countries such as Spain and Austria—where consent is presumed unless explicitly denied—consistently report participation rates exceeding 80%, compared to far lower rates in Opt-In countries like the United States or Germany. Behavioral research has shown that defaults influence decisions not because people are coerced, but because they often interpret default options as socially endorsed or administratively efficient. Similar dynamics can be observed in areas such as automatic enrollment in retirement savings plans or vaccination campaigns.[30]

Yet, implementing the Opt-Out model raises concerns about individual autonomy. A default assumption of consent does not necessitate conscious action and can overlook that consent is based on informed decision-making. Individuals with cognitive or psychological impairments may be deemed to have "agreed" to legal representation despite lacking the capacity to fully comprehend the significance of their decision. In this regard, the Opt-Out model may be perceived as paternalistic because it assumes the exercise of a right based on implied consent rather than explicit action by the individual.[31]

C. Ethical Considerations: Autonomy vs. Paternalism

The debate over the right to legal representation for involuntarily hospitalized individuals involves a fundamental ethical tension between autonomy and paternalism. This tension lies at the heart of mental health law and policy, where efforts to protect vulnerable individuals must be weighed against the obligation to respect their independent choices. In the context of involuntary hospitalization, this balance becomes especially

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[28] *See* Etheredge, *supra* note 25; Yan & Yates, *supra* note 25.

[29] Shai Davidai, Thomas Gilovich & Lee D. Ross, *The Meaning of Default Options for Potential Organ Donors*, 109 PROC. NAT'L ACAD. SCI. 15201 (2012) (examining how default rules influence individuals' willingness to participate in organ donation).

[30] *See* Etheredge, *supra* note 25.

[31] Joshua W. Ohde et al., *Presumed Consent with Opt-Out: An Ethical Consent Approach to Automatically Refer Patients with Cancer to Tobacco Treatment Services*, 39 J. CLINICAL ONCOLOGY 876, 877 (2021).

delicate: while some individuals may temporarily lack the capacity to make informed decisions, others may be competent but still subject to coercive interventions. Understanding the ethical foundations of both paternalism and autonomy is therefore essential to evaluating the normative justifications for mandatory legal representation.

This section begins by examining the concept of paternalism, including its various forms and the philosophical arguments that justify temporary restrictions on liberty for the sake of an individual's well-being. It then turns to the principle of autonomy, exploring its meaning, legal relevance, and the criteria used to assess decision-making capacity. Together, these discussions provide a conceptual framework for assessing the appropriate balance between protecting individuals' rights and ensuring their safety and dignity within involuntary psychiatric procedures.

1. Paternalism

Paternalism is generally defined as an intervention by a state, institution, or individual in another person's affairs, either against their will or without their explicit consent, to benefit them or prevent them from harm.[32] Paternalistic actions restrict individual liberty but are often justified by the goal of protecting individuals from self-inflicted harm.[33] Thus, an increased duty of care is imposed on the state or entity acting in a paternalistic manner.[34]

A distinction is commonly made between "soft" and "hard" paternalism.[35] Soft paternalism involves intervention only when the individual lacks the capacity to make an informed decision, as in cases of minors or people experiencing severe cognitive decline.[36] Hard paternalism, by contrast, intervenes in the decisions of individuals who are otherwise

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[32] Dominik Düber, *The Concept of Paternalism*, *in* 35 NEW PERSPECTIVES ON PATERNALISM AND HEALTH CARE 31, 33 (Thomas Schramme ed., 2015); Gerald Dworkin, *Defining Paternalism*, *in* 35 NEW PERSPECTIVES ON PATERNALISM AND HEALTH CARE 17, 19 (Thomas Schramme ed., 2015); Seana Valentine Shiffrin, *Paternalism, Unconscionability Doctrine, and Accommodation*, 29 PHIL. & PUB. AFFS. 205, 218 (2000).

[33] *See generally* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (8th ed. 2019) (providing a comprehensive account of the four principles of biomedical ethics: autonomy, beneficence, nonmaleficence, and justice); JASON HANNA, IN OUR BEST INTEREST: A DEFENSE OF PATERNALISM 20 (Oxford Univ. Press 2018) (defending paternalism as compatible with individual well-being and autonomy); Daniel Groll, *Paternalism and Rights*, *in* THE ROUTLEDGE HANDBOOK OF THE PHILOSOPHY OF PATERNALISM 119, 120 (Kalle Grill & Jason Hanna eds., 2018); Joel Feinberg, *Harm to Self*, *in* THE MORAL LIMITS OF THE CRIMINAL LAW 12–16 (1986).

[34] *See* HANNA, *supra* note 33, at 21–22.

[35] *See* sources cited *supra* note 32.

[36] *See* HANNA, *supra* note 33.

competent, as when the law mandates wearing a helmet while riding a motorcycle even for adult riders who are fully aware of the risks.[37] Critics of hard paternalism argue that individuals are in the best position to determine what is in their best interest and should, therefore, be allowed to make autonomous choices and bear responsibility for their consequences.[38] This distinction hinges on the question of decision-making competence.[39]

In essence, soft paternalism assumes that the individual's autonomy is not fully intact, and therefore, intervention serves to protect the person until they are capable of making their own decisions. It is grounded in the idea that true autonomy requires a minimal level of understanding and voluntariness. Hard paternalism, on the other hand, overrides the choices of individuals who are deemed fully competent, based on the belief that their decisions are irrational or harmful. This makes hard paternalism far more controversial, as it involves a deliberate infringement on autonomy in the name of protecting individuals from themselves.

The scholar Feinberg argued that paternalistic intervention is justified only when there is an immediate and substantial threat to an individual's well-being.[40] He noted that such intervention should be temporary, ceasing once the individual regains the ability to make independent decisions.[41] Similarly, the scholars Beauchamp and Childress proposed a framework for justifying paternalistic actions. According to their model, the justification for paternalism is strengthened when the benefit to an individual's well-being outweighs the infringement on autonomy.[42] Applying this formula to involuntarily hospitalized individuals, legal representation provides substantial benefits by ensuring individuals' procedural rights while imposing minimal harm to their autonomy.[43] Both perspectives suggest that, in such cases, a certain degree of paternalism is warranted to protect individuals' rights and interests.

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[37] Jason Hanna, *Hard and Soft Paternalism*, *in* THE ROUTLEDGE HANDBOOK OF THE PHILOSOPHY OF PATERNALISM 24 (Kalle Grill & Jason Hanna eds., 2018).

[38] Lucas Lixinski & Noam Peleg, *Paternalism in International Human Rights Law*, 33 DUKE J. COMPAR. & INT'L L. 1, 6–7 (2022).

[39] *Id.* at 6.

[40] *See* Feinberg, *supra* note 33.

[41] In the context of this Article, Feinberg's approach supports Mandatory Representation for involuntarily hospitalized individuals, provided they lack decision-making capacity. *See* HANNA, *supra* note 40..

[42] *See* Düber*, supra* note 32, at 35; Dworkin, *supra* note 32, at 21; Shiffrin, *supra* note 32, at 218.

[43] *See id.*

2. Autonomy

Autonomy is the right of individuals to govern their lives and make decisions free from undue external influence.[44] It includes both a negative component, which obligates others (including state authorities) to refrain from infringing on it, and a positive one, which requires others to respect and facilitate autonomous decision-making.[45] In the context of this Article, people with mental illness are considered to have legal capacity, meaning that their autonomy must be respected unless determined otherwise by a psychiatrist. Decision-making capacity is not binary but relative, influenced by both internal (cognitive and psychological) and external (social and legal) factors.[46]

These factors can take various forms. Cognitive factors may include impairments in memory, attention, or reasoning, such as those associated with dementia or traumatic brain injury. Psychological factors can involve acute symptoms like delusions, severe anxiety, or mood disturbances that affect judgment. Social factors may relate to coercion by family members or institutional pressures, while legal factors include procedural barriers, such as a lack of access to legal counsel or an inadequate explanation of rights. Together, these influences highlight the complexity and contextual nature of assessing decision-making capacity.

The leading model for assessing capacity is the MacArthur Competence Criteria, developed by Appelbaum and Grisso. This method evaluates the following four components: (1) to communicate; (2) the ability to understand relevant information; (3) the ability to appreciate the nature of the situation and its likely consequences; and (4) the ability to engage in rational decision-making. [47]

a. Ability to communicate a choice:

Individuals must be able to convey their decision. This refers to hospitalization or legal representation.[48] In the context of this Article, people

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[44] *See* BEAUCHAMP & CHILDRESS, *supra* note 33,

[45] JONATHAN PUGH, AUTONOMY, RATIONALITY AND CONTEMPORARY BIOETHICS 32 (2020).

[46] *See* BEAUCHAMP & CHILDRESS, *supra* note 33, at 111.

[47] *See* Paul S. Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study. I: Mental Illness and Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 105 (1995) [hereinafter Appelbaum & Grisso, study I); Paul S. Appelbaum et al., *The MacArthur Treatment Competence Study. II: Measures of Abilities Related to Competence to Consent to Treatment*, 19 LAW & HUM. BEHAV. 127 (1995) [hereinafter Appelbaum & Grisso, study II); Paul S. Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 LAW & HUM. BEHAV. 149 (1995) [hereinafter Appelbaum & Grisso, study III)].

[48] *See* Appelbaum & Grisso, study I, *supra* note 47, at 119.

with mental illness must be able to inform their caregiver whether they accept the proposal for hospitalization if such a proposal has been made.

b. Ability to understand relevant information:

Individuals must comprehend information regarding their condition, hospitalization, and the right to legal representation. Persons with mental illness must be able to understand the information provided by their caregiver regarding their condition, including the risks associated with the illness and the proposed treatment. The higher the level of risk involved in the treatment, the greater the required capacity to understand the conveyed information. In the context of this Article, persons with mental illness must understand their medical condition and be aware that they are involuntarily hospitalized, against which they have the right to petition the District Psychiatric Board (DPB) through legal representation. It may be assumed that not all involuntarily hospitalized persons with mental illness are capable of understanding their situation, including their right to legal representation.

c. Ability to appreciate the nature of the situation and its likely consequences:

Individuals must recognize the implications of hospitalization and legal representation. For example, a person may understand that legal proceedings are taking place and that they have the right to representation. However, if they believe the hospitalization is a mistake or the result of a conspiracy, they may fail to grasp that the situation genuinely applies to them—thus lacking appreciation despite factual understanding.

d. Ability to engage in rational decision-making:

Persons with mental illness must be able to engage in a rational decision-making process, which includes weighing the benefits of the proposed treatment and the risks involved, including the advantages and risks of alternative treatments and the absence of treatment.[49] Appelbaum and Grisso noted that the decision-making process must be based on common sense, but the decision itself does not need to be rational.[50] For a decision to be considered autonomous, it must be made without undue influence or external intervention.[51]

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[49] *See id.*

[50] *See id.* Thus, the fact that the decision-maker may prioritize a sense of belonging or their religious beliefs over the risk of significant bodily harm does not undermine the rational nature of the decision-making process.

[51] ISAIAH BERLIN, FOUR ESSAYS ON LIBERTY 38 (N.Y. OXFORD UNIV. PRESS, 1969).

D. Justifications for the Right to Representation

The recognition of a legal right to representation, particularly for individuals who are involuntarily hospitalized due to mental illness, requires both normative and practical justification. This section outlines the main justifications for establishing and upholding this right within involuntary psychiatric proceedings. These justifications are grounded in legal theory, empirical findings, and ethical considerations, highlighting the central role that legal representation plays in ensuring fairness, legitimacy, and respect for individual rights. The discussion proceeds in five parts: (a) the role of legal representation in ensuring due process; (b) its contribution to public confidence in the legal system; (c) its impact on case outcomes; (d) its influence on individuals' perception of fairness and compliance with treatment; and (e) its function in preventing arbitrary deprivation of liberty. Together, these rationales provide a comprehensive foundation for understanding the significance of legal representation in this context.

1. Ensuring Due Process

The right to due process is a fundamental legal principle requiring that before state authorities take action that infringes on an individual's rights,[52] a fair procedure must be followed.[53] This right is not limited to criminal proceedings but also applies to civil and administrative processes. In adversarial legal systems, such as the one in Israel, courts rely on the parties to present their arguments, a process that requires legal representation to ensure fairness.[54] The scope of due process has expanded to include cross-

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[52] *See generally* Ariel L. Bendor & Michal Tamir, *Human Dignity as a Chameleon*, 5 CARDOZO INT'L & COMPAR. L. REV. 739 (2022) (arguing that courts interpret and apply the concept of human dignity in line with the broader constitutional context, treating it as a "constitutional chameleon" rather than adhering solely to abstract theory or original intent); Ariel L. Bendor & Michael Sachs, *The Constitutional Status of Human Dignity in Germany and Israel*, 44 ISR. L. REV. 25, 46 (2011); *see generally* Aharon Barak, *Human Rights in Israel*, 39 ISR. L. REV. 12 (2006) (surveying the development, constitutional foundations, and judicial interpretation of human rights in Israel).

[53] *See* BERLIN, *supra* note 51, at 66.

[54] Richard B. Saphire, *Specifying Due Process Values: Toward a More Responsive Approach to Procedural Protection* 127 U PA L. REV. 111, 113 (1978); Herbert Hovenkamp, *The Political Economy of Substantive Due Process,* 40 STAN L. REV. 379, 381 (1988); Nicholas N. Kittrie, *Compulsory Mental Treatment and the Requirements of "Due Process",* 21 OHIO ST. L.J. 28, 34 (1960).

examination, legal representation,[55] and adequate procedural safeguards.[56] Denial of representation risks undermining due process and the fairness of the proceedings. [57]

2. Enhancing Public Confidence in the Legal System

A second justification for granting the right to legal representation is the enhancement of public trust in the judicial system.[58] The representation of an individual by an attorney is not merely a personal interest but also a public one. Legal representation ensures that decisions made by the system are reached only after thorough examination and hearing of all the parties, while maintaining the neutrality of the court. [59] A system that guarantees procedural fairness signals to the public that justice is not only done but seen to be done. This perception reinforces the legitimacy of legal outcomes, encourages respect for judicial authority, and promotes greater voluntary compliance with legal decisions.[60]

In the absence of representation, the judge is required to guide the unrepresented party, a situation that may compromise judicial neutrality and undermine public confidence. This is because judicial involvement in assisting one side—even with the intention of ensuring fairness—can create a perception of partiality, and subconscious biases may influence how and to what extent assistance is offered. [61]

Yet, this justification is relevant primarily to criminal and complex civil proceedings; in simpler proceedings, such as those in the Small Claims Court,

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[55] Leonard S. Rubenstein*, Procedural Due Process and the Limits of the Adversary System,* 11 HARV. C.R-C.L L. REV. 48, 52 (1976); Ellen Sward, *Values, Ideology, and the Evolution of the Adversary System*, 64 IND. L.J. 301, 335–36 (1989); Martin H. Redish & Lawrence C. Marshall*, Adjudicatory Independence and the Values of Procedural Due Process*, 95 YALE L. J.*,* 455, 485–86 (1986); Amalia D. Kessler*, Inquisitorial Tradition: Equity, Procedure, Due process, and the Search for an Alternative to the Adversarial*, 90 CORNELL L. REV. 1181, 1231 (2005); Adrian Zuckerman**,** *No Justice Without Lawyers—The Myth of an Inquisitorial Solution*, 33 C.J.Q. 355,356 (2014).

[56] *See* sources cited *supra* note 54.

[57] Grundgesetz [GG] [Basic Law] § 103, translation at https://www.gesetze-im-internet.de/englisch_gg/englisch_gg.html [https://perma.cc/W4QR-YC5A]; Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc. A/810, art. 8 (Dec. 10, 1948); U.S. CONST. amend. V.

[58] Meghan H. Morgan, *Standby Me: Self-Representation and Standby Counsel in a Capital Case*, 16 CAP. DEF. J. 367, 372 (2004).

[59] Redish & Marshall, *supra* note 58, at 488.

[60] Denise Meyerson, *Why Should Justice Be Seen to Be Done?*, 34 CRIM. JUST. ETHICS 64, 75 (2015).

[61] Rubenstein, *supra* note 55, at 66.

the effect on public confidence is less significant.[62] Evidence of this can be found in the legislative prohibition against legal representation in small claims courts. This prohibition is generally aimed at promoting procedural efficiency and accessibility rather than enhancing public confidence. The rationale is that small claims are designed to be informal and straightforward, allowing litigants to represent themselves without the need for legal expertise. Introducing attorneys into such proceedings could complicate the process, increase costs, and create imbalance rather than trust.[63] Conversely, when the public perceives that the judicial system takes the unique needs of persons with mental illness seriously, it is more likely to view it as a fair, empathetic, and professional institution that seeks to protect the vulnerable and ensure justice.

3. Impact on Case Outcomes

A third justification is a higher likelihood of success for the represented party.[64] The right to legal representation is perceived as part of the right to a fair procedure because it helps increase an individual's chances of success. Studies conducted in the criminal arena have shown that legal representation indeed improves the likelihood of success for defendants and suspects.[65] In the realm of civil claims, this issue has not yet been thoroughly researched but a limited number of studies have found that represented individuals had higher chances of success than unrepresented ones, particularly in cases concerning social rights in the U.S.[66] Another study conducted in the U.S. found that persons with mental illnesses who were involuntarily hospitalized were more frequently discharged if they had legal representation and that the rate of rehospitalization did not differ between represented and unrepresented individuals.[67] These studies collectively reinforce the claim that access to legal representation significantly enhances the chances of a

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[62] For further discussion, see the book by TAL HAVKIN AND YIGAL NIMRODI, *THE SMALL CLAIMS LAWSUIT* (2017).

[63] Alexander Domanskis, *Small Claims Courts: An Overview and Recommendation*, 9 U. MICH. J.L. 590, 594 (1976).

[64] Rebecca E. Zietlow, *Two Wrongs Don't Add up to Rights: The Importance of Preserving Due Process in Light of Recent Welfare Reform Measures*, 45 AM. U. L. REV. 1111, 1114 (1996).

[65] *See, e.g.*, Paul Heaton, *Enhanced Public Defense Improves Pretrial Outcomes and Reduces Racial Disparities*, 96 IND. L.J. 701, 721–28 (2021).

[66] *See generally* Ronald P. Hammer & Joseph M. Hartley, *Procedural Due Process and the Welfare Recipient: A Statistical Study of AFDC Fair Hearings in Wisconsin*, 1978 WIS. L. REV. 145 (1978) (analyzing procedural due process in welfare fair hearings through empirical data); Karl Monsma & Richard Lempert, *The Value of Counsel: 20 Years of Representation before a Public Housing Eviction Board*, 26 L. & SOC'Y REV. 627 (1992) (assessing the impact of legal representation in housing eviction proceedings).

[67] HERBERT M. KRITZER, LEGAL ADVOCACY, 111–20 (Univ. of Mich. Press, 1st ed. 1988).

favorable outcome, particularly for individuals facing structural or cognitive disadvantages. [68]

In the context of involuntary hospitalization, a study conducted by the authors of this Article examined the effect of legal representation on the rate of discharges and readmissions in involuntarily admitted individuals in Israel.[69] The study found that legal representation increased the rate of discharge but did not affect the rate of rehospitalization. It is reasonable to assume that the longer the interval between hospitalizations, the more successful the treatment was during hospitalization. Therefore, legal representation appears to increase an individual's chances of a successful outcome.

4. Perceived Fairness and Compliance with Treatment

A fourth justification concerns individuals' internal perceptions and acceptance of the decision.[70] Studies conducted in this field have demonstrated a correlation between an individual's sense of fairness toward the authority and its decisions and their perception that their procedure was conducted fairly.[71] This connection is particularly significant in contexts involving persons with mental illness, where fostering a sense of fairness may directly impact their willingness to cooperate with institutional decisions.

According to some scholars, the reason is that procedural justice signals to individuals that society respects them and their voices, thereby strengthening their trust in the system. The perception of justice and fairness fosters a sense of belonging to a broader group that requires laws and restrictions.[72] The assumption is that this sense of belonging and fairness increases the likelihood that individuals will accept the restrictions imposed on them by the authorities or the court, thereby enhancing their cooperation with the authorities and preventing the recurrence of similar situations. Thus, the right to legal representation fulfills an individual's natural right to resist

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[68] *See generally* Russell Engler, *Connecting Self-Representation to Civil* Gideon*: What Existing Data Reveal about When Counsel Is Most Needed*, 37 FORDHAM URB. L. J. 37 (2010) (analyzing empirical studies to identify in which proceedings legal counsel most affects outcomes and proposing that civil *Gideon* efforts focus on cases involving basic needs where full representation is essential).

[69] Yaacov Cohen et al., *The Effect of Legal Representation on Clinical Measures in Involuntarily Admitted Psychiatric Patients: A Retrospective Study*, 13 ISR. J. HEALTH POL'Y RES. 58, 58–59 (2024).

[70] *See generally* LIND E. ALLAN & TOM R. TYLER, SOCIAL PSYCHOLOGY OF PROCEDURAL JUSTICE (Plenum Press 1988) (exploring psychological foundations of perceptions of fairness in legal and organizational procedures).

[71] JOHN THIBAUT & LAURENS WALKER, PROCEDURAL JUSTICE 16 (Lawrence Erlbaum Associates, Inc. 1975).

[72] *See generally* ALLAN & TYLER, *supra* note 70.

attempts to infringe on their rights, preventing feelings of frustration and helplessness toward the system.[73] This, in turn, increases the likelihood that the procedure will be perceived as fair from the perspective of the affected individuals, making it easier for them to accept the outcome and submit to legal authority with understanding and acceptance, after having had their day in court.

Individuals' experiences are enhanced when they feel that they can voice their concerns (*voice*), that their arguments have been attentively heard (*validation*), that they have been treated with courtesy and care, and that they have received all the relevant information regarding their case. The outcome of such a process is that individuals feel respected (*respect*). This sense of respect enables them to make decisions from a position of strength rather than weakness.[74] The question arises as to whether these principles also apply to persons with mental illness who are involuntarily hospitalized because of severe mental illness that impairs their judgment and reality testing: does mental illness affect their experience in a way that the above conditions become irrelevant because they may be unable to appreciate the fairness?[75]

Studies have found that reliance on procedural justice as an indicator of satisfaction is even greater in marginalized groups, particularly persons with severe mental illness.[76] A study examined the functioning of U.S. courts that

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[73] *See generally* Lawrence B. Solum, *Procedural Justice*, 78 S. CAL. L. REV. 181 (2004) (articulating a foundational account of procedural justice grounded in participation and accuracy); Rebecca Hollander-Blumoff, *The Psychology of Procedural Justice in the Federal Courts*, 63 HASTINGS L. J. 127 (2011).

[74] E. Allan Lind et al., *Voice, Control and Procedural Justice: Instrumental and Non-Instrumental Concerns in Fairness Judgments*, 59 J. PERSONALITY & SOC. PSYCH. 952, 953 (1990); John T. Monahan et al., *Coercion in the Provision of Mental Health Services: The MacArthur Studies*, in *Research in Community and Mental Health: Coercion in Mental Health Services International Perspectives* 13, 26–27 (Bruce D. Sales & Saleem A. Shah eds., 2001) ("[A] patient's beliefs that others acted out of genuine concern, treated the patient respectfully and in good faith, and afforded the patient a chance to tell his or her side of the story, are associated with low levels of experienced coercion."). *See also* Maria Slater, *Revolving Doors of Hospitalization and Incarceration: How Perceptions of Procedural Justice Affect Treatment Outcomes*, 27 WM. & MARY J. RACE GENDER & SOC'Y. JUST. 261 (2021) (using "procedural justice" to refer to a participant's subjective experience and perception of fairness in the case disposition process).

[75] Russell Cropanzano et al., *Using Social Exchange Theory to Distinguish Procedural From Interactional Justice*, 27 GRP. & ORG. MGMT. 324, 328 (2002).

[76] Charles W. Lidz et al., *Factual Sources of Psychiatric Patients' Perceptions of Coercion in the Hospital Admission Process*. 155 AM. J. PSYCHIATRY 1254, 1255 (1998); Riittakerttu Kaltiala-Heino et al., *Impact of Coercion on Treatment Outcome*, 20 INT'L. J.L. & PSYCHIATRY 311, 319–20 (1997); Brian G. McKenna et al., *Patient Perception of Coercion on Admission to Acute Psychiatric Services: The New Zealand Experience*, 22 INT'L J.L. & PSYCHIATRY 143, 147–48, 151 (1999); *see generally* Lucie E. White, *Subordination, Rhetorical Survival Skills, and Sunday Shoes: Notes on the Hearing of Mrs. G.*, 38 BUFF. L. REV. 1 (1990) (discussing the importance of legal representation for marginalized populations, particularly in cases where rigid procedural processes exist, to ensure that the individual's voice is genuinely heard and not merely heard for appearances). Regarding the

handle cases involving defendants with mental illness, similar to the role of the District Psychiatric Board (DPB) in Israel.[77] The study analyzed judicial conduct toward defendants with mental illness and found that judges who showed interest and worked collaboratively with defendants to find solutions to their problems led to greater cooperation with the system and the medical treatment provided.[78] Another observed phenomenon, which may be directly related to treatment, was that some of the released individuals did not return for rehospitalization.[79]

Similarly, in Israel, there has been recognition of the possibility that legal representation helps involuntarily hospitalized persons with mental illness cooperate with their caregivers. In one study, psychiatrists treating persons with mental illness in closed psychiatric wards were asked for their opinions on the effect of legal representation on patient cooperation with medical treatment.[80] Eighty-four percent of respondents stated that they believed legal representation positively influenced persons with mental illness by helping them accept the fact that they were involuntarily hospitalized.[81]

5. Preventing Arbitrary Deprivation of Liberty

A fifth justification for the right to legal representation concerns the risk of infringement on individual liberty. The more severe the infringement, the greater the importance of granting individuals the right to representation to

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question of whether the experiences of individuals with mental health conditions who were involuntarily hospitalized were authentic, the answer is affirmative. Studies have found that individuals with mental health conditions accurately described the conditions of their hospitalization and the conversations held between them and the physicians. William Gardner et al., *Two Scales for Measuring Patients' Perception of Coercion During Mental Hospital Admission*, 11 BEHAV. SCI. & L. 307, 318–19 (1993).

[77] Heathcote W. Wales et al., *Procedural Justice and the Mental Health Court Judge's Role in Reducing Recidivism*, 33 INT'L J.L. & PSYCHIATRY 265, 270 (2010).

[78] *Id.*; *see also* Nahama Broner et al., *The Effect of Homelessness, Housing Type, Functioning, and Community Reintegration Supports on Mental Health Court Completion and Recidivism*, 5 J. DUAL DIAGNOSIS 323, 323–56 (2009) (finding that stable housing and community supports significantly improved mental health court completion rates and reduced recidivism); Michele Cascardi et al., *Procedural Justice in the Context of Civil Commitment: An Analogue Study*, 18 BEHAV. SCI. & L. 731, 734–36 (2000) (finding that perceptions of fairness in civil commitment hearings were strongly associated with greater acceptance of outcomes, even when the decision was unfavorable).

[79] *Id.*

[80] This study was conducted by one of the authors. *See* Yaacov Cohen, *Legal Representation of Mentally Ill Patients Before District Psychiatric Boards – The Psychiatric Perspective* (LL.M. thesis, Bar-Ilan Univ., Faculty of Law, 2015).

[81] *See id.* To be clear, those findings reflect the subjective opinions of caregivers, and the data have not been empirically tested.

protect it.[82] The Supreme Courts of Israel and the U.S. have extended the right to legal representation to some family law cases, recognizing it as a fundamental right in certain situations.[83]

Concerning involuntary hospitalization, the infringement on individuals' liberty is particularly severe. This is because it deprives them of their freedom of movement. Justice Elon described involuntary hospitalization as "one of the most severe and oppressive forms of deprivation of liberty,"[84] reinforcing the justification for granting legal representation to persons with mental illness, similarly to defendants in criminal proceedings.[85]

The question arises as to how the effective implementation of the right to legal representation for persons with mental illness can be ensured. Although the importance of this right is evident, its implementation depends largely on the functionality of the legal and systemic framework in which it is provided. A comparison of legal representation models in the U.S. and Israel offers insight into how mechanisms can be designed to best serve the justifications presented, taking into account the unique characteristics of persons with mental illness and examining the extent of autonomy granted to them in this context. This analysis is necessary to identify the inherent challenges and advantages of each system and to assess how these factors influence the effectiveness of the process and the sense of fairness among involuntarily hospitalized individuals.

There is consensus about the importance of legal representation for persons with mental illness who are involuntarily hospitalized, with the aim of ensuring their well-being and rights. The vulnerable condition of this population, particularly in the early stages of hospitalization, necessitates intervention to guarantee a fair procedure. Therefore, we need to examine the legal representation model established in Israel's Mental Health Act to ensure that it properly balances the principle of individual autonomy with paternalistic considerations arising from the temporary or ongoing incapacity

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[82] CivA 6810/97 Ben Shoshan v. Ben Shoshan, 51(5) PD 375 (1997) (Isr.). In that case, the Supreme Court of Israel characterized family law proceedings as "matters of life and death" and, consequently, mandated the appointment of legal counsel for the appellant while remanding the case to the District Court. *Cf.* Boddie v. Connecticut, 401 U.S. 371, 379–82 (1971) (discussing the importance of due process in certain kinds of high-stakes circumstances).

[83] *See* Boddie v. Connecticut, 401 U.S. 371 (1971) (holding that due process prohibits denying access to divorce proceedings based on inability to pay court fees); CivA 6810/97 Ben Shoshan v. Ben Shoshan, 51(5) PD 375 (1997) (Isr.) (emphasizing the importance of legal representation in family law proceedings as a means of ensuring procedural fairness and protecting vulnerable litigants).

[84] *Id.*

[85] *See* CrimA 2060/97 Wilenchik v. Dist. Psychiatrist, 52(1) PD 697, 707 (1998) (Isr.).

of hospitalized individuals to make informed decisions. This examination requires an in-depth assessment of the impact of legal representation on procedural fairness and the safeguarding of hospitalized individuals' procedural rights, with the goal of formulating a moral and legal justification for their right to representation.

III. THE LEGAL FRAMEWORK IN ISRAEL: THE MENTAL HEALTH ACT

This section provides a legal and historical overview of the right to legal representation for involuntarily hospitalized individuals in Israel. It traces the evolution of this right from its early recognition in 1955, through the enactment of the Mental Health Act in 1991, to the significant legislative development brought about by Amendment No. 5 in 2004. The section examines the key provisions of the law, including the establishment of District Psychiatric Boards, procedural safeguards, and the introduction of publicly funded legal representation. Special attention is given to the rationale behind the amendment, the objections raised during the legislative process, and the practical implementation of the right to legal counsel. This foundational analysis sets the stage for the normative discussion later in the Article regarding the scope and structure of this right.

A. Introduction

The Mental Health Act,[86] enacted by the Israeli Parliament (known as the Knesset) on December 11, 1990, regulates three types of

[86] *See* § 6, Mental Health Act, 2004 (Isr.).

hospitalization:[87] voluntary, involuntary criminal, and involuntary civil.[88] This Article focuses on involuntary civil hospitalization, a process that begins with an order issued by the District Psychiatrist for a compulsory psychiatric evaluation of an individual.[89] The District Psychiatrist is authorized to order an individual to undergo urgent or non-urgent compulsory evaluation if *prima facie* evidence is presented regarding the existence of the following conditions: (a) mental illness; (b) immediate or non-immediate danger to oneself or

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[87] For the purpose of the following discussion, the definitions and grounds used by the Israeli legislature concerning the examination process prior to issuing a civil hospitalization order will be presented below. Section 6 of the Mental Health Act states that:

> [A] district psychiatrist may issue a written order for an individual to be urgently brought for a psychiatric evaluation if prima facie evidence is presented indicating that all of the following conditions are met: (a) he is suffering from an illness as a result of which his capacity for judgment or for assessment of reality is severely impaired; (b) he is liable to endanger himself of other persons by immediate and physical danger; (c) he refuses to be examined by a psychiatrist.

Id.

Accordingly, three conditions must be met for the district psychiatrist to order a forced psychiatric evaluation:

1. A mental illness of such severity that it impairs the individual's judgment or ability to assess reality.
2. An immediate danger to oneself or others.
3. A refusal to undergo a psychiatric evaluation.

Israeli case law has established that, for the third condition—refusal to be examined by a psychiatrist—to be satisfied, the refusal must be explicitly expressed to a psychiatrist alone and not to a physician from another field, including a general practitioner. *See generally* Moshe Kalian & Eliezer Witztum, *The Israeli Model of the "District Psychiatrist" A Fifty-Year Perspective* 43 (3) ISR. J.PSYCHIATRY & RELATED SCI. 181 (2006) (providing an overview of the role of the Israeli District Psychiatrist ("DP")).

[88] *See* Arie Bauer et al., *Trends in Involuntary Psychiatric Hospitalization in Israel 1991–2000*, 30 INT'L J.L. & PSYCHIATRY 60, 61 (2007).

> [A]rt 4 of the Law regulates voluntary hospitalization. In case a patient admitted voluntarily requires to be discharged against the medical staff opinion he has to fill in a written form stating that s/he takes her/his own responsibility for every consequence of her/his premature discharge. In instance that her/his mental state is so severe that it matches the criteria for involuntary hospitalization the Director must require an involuntary hospitalization order by the District Psychiatrist through the compilation of a well-detailed written psychiatric report. If the District Psychiatrist refuses to issue such an order the patient should be discharged within 48 h of the admission.

Id.

[89] *See* Yaacov Cohen et al., *The Effect of Legal Representation on Clinical Measures in Involuntarily Admitted Psychiatric Patients: A Retrospective Study*, 13 ISR. J. HEALTH POL'Y RESCH. 59, 60 (2023).

others; and (c) refusal to undergo psychiatric evaluation.[90] Additional grounds for non-urgent involuntary hospitalization exist beyond non-immediate danger to oneself or others, including: (a) significantly impaired ability to care for one's basic needs; (b) causing severe suffering to others in a manner that disrupts their way of life; and (c) causing severe harm to property.[91]

The District Psychiatrist may order urgent or non-urgent compulsory hospitalization if they are persuaded, based on the findings of the evaluation, that the individual suffers from mental illness, poses a danger, and there is a causal link between the mental illness and the danger.[92] In cases of non-urgent compulsory hospitalization, the order is implemented only after 24 hours to allow the individual to file an appeal. If an appeal is filed, the hospitalization order is delayed until the District Psychiatric Board convenes.[93]

The hospitalization order is valid for seven days and may be extended for an additional seven days upon a written, reasoned request from the hospital's department head.[94] Hospitalized individuals may appeal these orders before the District Psychiatric Board (DPB) in writing or orally, but the right to appeal is not granted automatically and is available only to hospitalized individuals who seek release.[95] If the hospital wishes to extend the hospitalization beyond 14 days, it must submit a written request to the District Psychiatric Board.[96]

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[90] *See* § 6, Mental Health Act, 2004 (Isr.).

[91] *Id.* § 7.

[92] *Id.* § 9.

> If the district psychiatrist is convinced, based on a psychiatric evaluation, that the conditions set forth in Section 6(1) and (2) are met and that a causal link exists between these two conditions, they may issue a written order for the individual to be brought to the hospital and urgently hospitalized. (b) If the district psychiatrist is convinced, based on a psychiatric evaluation, that the conditions set forth in Section 7(1) and (2) are met and that a causal link exists between these two conditions, they may issue a written order for the individual to be brought to the hospital and hospitalized.

Id.

[93] *Id.* § 13.

[94] *Id.* § 10(a) (stating "[t]he duration of hospitalization pursuant to a hospitalization order shall not exceed seven days from the date of admission, except as provided by this law.").

[95] *Id.* § 12.

[96] The hearing before the District Psychiatric Board is mandatory and applies to all involuntarily hospitalized individuals, regardless of whether they have previously filed an appeal. Arlene Kanter & Uri Aviram, *Israel's Involuntary Outpatient Commitment Law: Lessons from the American Experience,* 29 ISR. L. REV. 565, 577 (1995) (asserting that "[t]he district

The District Psychiatric Board comprises three professionals: a lawyer and two psychiatrists, the lawyer serving as the chair.[97] The Board's decision must be reasoned, and general statements such as "poses a danger to oneself or others" without supporting evidence are insufficient. [98]

Another option available to the District Psychiatrist and the District Psychiatric Board is ordering compulsory outpatient treatment, requiring the individual to attend mental health clinics, receive medication, and undergo monitoring.[99]

The burden of proof regarding the need for continued compulsory hospitalization rests on the caregivers.[100] The Supreme Court of Israel has addressed the evidentiary basis required for the District Psychiatric Board and the standard of proof necessary to meet the burden of evidence for extending hospitalization.[101] The Supreme Court of Israel determined that the burden of proof is similar to that of civil proceedings, requiring proof by

psychiatrist's decision to grant or refuse a hospitalization order or an order for involuntary outpatient commitment may now be appealed to the Psychiatric Committee.").

[97] § 24, Mental Health Act, 2004 (Isr.).

[98] For example, in AdmA (DC TA) 689/98 Anonymous v. District Psychiatric Board, PM 5758(3) 145 (1998) (Isr.), the court held that a hospitalization request must be supported by specific, concrete facts rather than general, vague, or ambiguous descriptions. The decision must be grounded in case-specific evidence. For example, if the patient is alleged to be aggressive or violent, the request must include a detailed account of the specific incidents in which they were involved. This includes the factual basis of the alleged violent behavior, the severity of the incidents, the circumstances leading up to the violence (if any), as well as the time and place of occurrence. A mere statement by a physician asserting that an individual with a mental health condition is "violent" or "on the verge of an outburst" is insufficient to justify hospitalization.

[99] Alexander Teitelbaum et al., *Comparison Between Two Legal Indications for Compulsory Outpatient Treatment in Israel*, 23 MED. & L. 607, 607–08 (2004).

[97] CivA 8000/07 Att'y Gen. v. Ploni, 66(2) PD 721 (2012) (Isr.) (holding that the evidentiary standard required of the District Psychiatric Board in decisions to extend involuntary hospitalization is the civil standard of preponderance of the evidence, while also emphasizing that the severity of the liberty deprivation requires qualitatively and quantitatively sufficient proof).

[101] *Id.* at 33.

a preponderance of the evidence (at least 51% in favor of the claimant),[102] in contrast to the American approach, which requires at least 75%.[103]

Decisions of the District Psychiatric Board may also be appealed to the Israeli District Court. [104] As part of the appeal process, the court must ensure that the District Psychiatric Board's decision to extend compulsory hospitalization meets the standards in the *Wilenchik* case.[105] In that decision, the Supreme Court of Israel ruled that deprivation of liberty for a person with mental illness is permissible only for a legitimate purpose and in a proportional manner.[106] Thus, involuntary hospitalization or its continuation is not permitted if treatment goals or public safety can be achieved by less restrictive means, such as compulsory outpatient treatment.[107]

The Supreme Court of Israel also ruled that any measure adopted must achieve its legitimate purpose while minimizing harm to the individual with mental illness. This is in accordance with the principles of human rights protection and proportionality. To ensure compliance with these requirements, it was determined that any decision regarding deprivation of liberty must be subject to strict judicial review and that individuals who forcefully object to their hospitalization must be represented by an attorney.[108] To conclude, the *Wilenchik* ruling established the foundation for the obligation to appoint state-funded legal representation for involuntarily hospitalized individuals, even in civil proceedings. This foundation was later codified in Amendment No. 5 to the Mental Health Act, discussed below.

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[102] In Israel, there are two primary standards of proof: "preponderance of the evidence" (requiring a probability of 51%) in civil proceedings and "beyond a reasonable doubt" in criminal cases. However, the legislature has not explicitly defined the standard of proof required for involuntary hospitalization. Given the significant deprivation of liberty involved, which parallels certain aspects of criminal proceedings, the appropriate burden of proof remains a subject of legal debate. The Supreme Court of Israel resolved this question and ruled that the required standard of proof for civil involuntary hospitalization is "preponderance of the evidence."

[103] Addington v. Texas, 441 U.S. 418, 431–33 (1979).

[104] § 29, Mental Health Act, 2004 (Isr.). The appeal must be filed within 45 days and is heard by a single judge.

[105] CrimA 2060/97 Wilenchik v. District Psychiatrist, 52(1) PD 697, 707 (1998) (Isr.).

[106] *Id.* at 708.

[107] *Id.* at 712.

[108] Virginia A. Hiday & Rodney R. Goodman, *The Least Restrictive Alternative to Involuntary Hospitalization, Outpatient Commitment: Its Use and Effectiveness,* 10 J. PSYCHIATRY & L. 81, 82 (1982).

B. The Right to Legal Representation for Persons with Mental Illness

The right of an involuntarily hospitalized person to present arguments before the District Psychiatric Board has existed in Israel since 1955.[109] Hospitalized individuals have the right to argue their case before the board and seek legal assistance from an attorney.[110] Nevertheless, exercising this right was the sole responsibility of the individual, requiring self-funding or financial support from family members. In practice, the vast majority of hearings before the board were conducted without legal representation. [111] The small minority of people who were represented by attorneys received assistance primarily from human rights organizations. [112] Several explanations may account for the lack of representation: (a) many involuntarily hospitalized individuals could not afford to hire an attorney; (b) the restrictive environment of involuntary hospitalization limited their ability to contact an attorney because they are often unable to communicate with people outside the psychiatric facility, or contact was only possible through family members, who did not always share the hospitalized individual's perspective or interest in seeking release; or, (c) the mental state of individuals in involuntary hospitalization often impaired their ability to initiate contact with an attorney.[113]

The absence of legal representation led to few cases being reviewed by the Israeli District Court, let alone the Supreme Court of Israel.

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[109] Treatment of Mental Patients Law, 1955 (Isr.).

[110] § 26, Mental Health Act, 2004 (Isr.). A similar provision existed in Mental Health Act of 1955.

[111] Schnit Committee for the Examination of the Functioning of the District Psychiatric Boards, Final Report (2000). Additionally, in the case file study conducted by the authors of this Article, which examined the records of individuals involuntarily hospitalized in 2000 and 2010 across three hospitals in Jerusalem, it found that in 2000, only three individuals with mental health conditions were represented by attorneys.

[112] *See* Bauer et al., *supra* note 85.

[113] Sagit Mor*, With Access and Justice for All,* 39 CARDOZO L. REV. 611, 614 (2017) (arguing that access to justice is a pivotal concept in promoting the rights of persons with disabilities, since accessibility, in its broad sense, is the foundation for the entire struggle for disability rights; it is the key for participation in the public sphere and for personal decision-making in the private sphere). The author enumerates the difficulties individuals with disabilities face in accessing the courts. Among other points, the author highlights the correlation between individuals with disabilities and low socioeconomic status. In the absence of income, this population is often unable to afford attorney's fees or even court filing fees. The author also notes the physical limitations faced by individuals with disabilities, particularly those institutionalized in closed facilities. "People in closed institutions are, therefore, under a constant 'social curfew' and are physically barred from filing a legal claim." *Id.* at 636. *See also* Catherine R. Albiston & Rebecca L. Sandefur*, Expanding the Empirical Study of Access to Justice,* 2013 WIS. L. REV. 101, 115 (2013); Deborah L. Rhode, *Whatever Happened to Access to Justice,* 42 LOY. L. A. L. REV 869, 890–91 (2009); Arlene S. Kanter*, Let's Try Again: Why the United States Should Ratify the United Nations Convention on the Rights of People with Disabilities,* 35 TOURO L. REV. 301, 324–25 (2019).

Consequently, judicial oversight over the District Psychiatric Board decisions was virtually nonexistent. In the few cases reviewed by the Israeli District Courts, harsh criticism was directed at the Board's procedures.[114] To prevent the recurrence of such issues, district courts recommended granting legal representation in Board hearings.[115] Nevertheless, the courts did not overturn Board decisions solely because of the lack of representation. Rather, if an error was revealed in a Board decision, the court overturned it, and where the court could rectify procedural deficiencies, the decision was not invalidated strictly on the grounds of non-representation.[116]

In 2000, the Shnit Committee was appointed to review the operations of the District Psychiatric Board and recommended establishing a mandatory right to legal representation in Board hearings, a Mandatory Representation model.[117] In parallel, discussions in the Knesset were held about amending the law.[118] Under the proposed legislation, an Opt-In model was recommended, providing state-funded representation through the Legal Aid Department in civil hospitalization cases and through the Public Defender's Office in criminal hospitalization cases.[119]

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[114] C.A. (DC TA) 368/00 Anonymous v. The District Psychiatric Board (2000) (Isr.) (unreported).

[115] AdmA (DC TA) 689/98 Anonymous v. The District Psychiatric Board, PM 5758(3) 145 (1998) (Isr.) ("It can be assumed that if individuals were represented by attorneys before the psychiatric boards, some of these failures could have been prevented . . . . Perhaps the time has come to consider granting legal representation to patients appearing before psychiatric boards, as their decisions often have critical implications."). *See also* C.A. (DC TA) 368/00 Anonymous v. The District Psychiatric Board (2000) (Isr.) (unreported). ("I cannot avoid mentioning the deep concern that accompanies me when hearing these appeals, in light of the fact that only a few citizens, who are unlawfully involuntarily hospitalized, receive legal representation and have the opportunity to properly bring their appeals before the courts.").

[116] *Id.*

[110] Shnit Committee Report on the District Psychiatric Board (2000) (Isr.) [in Hebrew].

[118] *See* Proposed Law for the Treatment of the Mentally Ill, 1990, Knesset Bills 240 (June 11, 1990) (Isr.) [in Hebrew] (laying the foundation for the current Mental Health Act).

[119] Legal Aid Law, 1972, SH No. 678 p. 182, § 2(a)(2) (Isr.) [in Hebrew]. In Israel, legal aid is provided under the Legal Aid Act and is generally contingent on two conditions: the applicant must meet an income test set forth in the Legal Aid Regulations and must also demonstrate a valid legal claim. However, when it comes to representation before the District Psychiatric Board, an exception has been established—legal aid is granted automatically, without assessing the patient's financial eligibility or the legal merits of their case. In other words, any involuntarily hospitalized individual is entitled to legal representation before the board, regardless of their financial status, even if they are affluent. However, when appealing a decision of the District Psychiatric Board, legal aid is contingent upon the existence of a legal cause of action. Notably, even in such appeals, legal aid is not subject to an income test.

Eventually, the law was amended to provide an Opt-In right to legal representation rather than Mandatory Representation.[120] Section 29A of the Mental Health Act grants a state-funded right to legal representation before the District Psychiatric Board for individuals undergoing civil involuntary hospitalization. During the committee deliberations, several psychiatrists opposed the appointment of an attorney for three reasons. First, legal representation might lead to the massive release of involuntarily hospitalized individuals with mental disorders before the completion of their treatment, causing harm to many. According to psychiatrists, such a situation could increase the percentage of repeated involuntary hospitalizations. Second, the legal intervention in involuntary hospitalization procedures (which are a small percentage of all hospitalizations) would require the investment of valuable medical time and come at the expense of treating other individuals with mental disorders. Third, recognizing legal representation would harm the therapist-patient relationship, which is essential for successful treatment.[121] This harm would arise because, at a hearing in the presence of an attorney, the psychiatrist would be perceived as opposing the release of hospitalized individuals, whereas the attorney would appear to advocate for the patients by assisting them in securing their release.[122]

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[120] *See* § 29, Mental Health Act, 2004 (Isr.).

[121] The doctor-patient relationship is at the heart of the provision of treatment and consequently is intensively discussed in the literature of bioethics and medical law. A significant point highlighted in this literature is that a good doctor-patient relationship, based on trust, contributes to the treatment's success. *See* Susan D. Goold & Mack Lipkin**,** *The Doctor–Patient Relationship: Challenges, Opportunities, and Strategies*, 14 J. GEN. INTERNAL MED**.** 26, 27–28 (1999).

[122] *See generally* Sergey Raskin et al., *Legal Involvement in Psychiatric Care*, 144 HAREFUAH 696, 751 (2005). [Article in Hebrew, Abstract in English] (arguing that "[T]he decision of the regional psychiatrists' committee or the court is liable to worsen the patients' mental health status and even to accelerate aggression towards self or others. In rare cases a premature discharge based on legal considerations rather than medical evaluation may result in suicide, as demonstrated in one of the vignettes . . . . [T]he study showed a shorter stay in the community in the first group (42%) compared to 75% stay in the community in the second group, after six months. We are of the opinion that the current provision of legal assistance is lacking the necessary balance between medical and legal considerations; the 'wish for freedom' as a default, although illogical, is within the new system of legal aid, and is more considerate and important than the 'best interests' of the patient and his health."). The study, conducted shortly after the amendment, included a small number of cases and concluded that legal representation may increase the rate of involuntary rehospitalizations among represented individuals due to early discharge. Additionally, the authors argued that legal representation might negatively impact the relationship between the caregiver and the individual with a mental health condition. *See also* Alexander Teitelbaum et al., *Comparison Between Two* Legal *Indications for Compulsory Outpatient Treatment in Israel,* 23 MED. & L. 607, 608 (2004); Daniel Argo et al., *A Comparison of Decisions to Discharge Committed Psychiatric Patients Between Treating Physicians and District Psychiatric Committees: An Outcome Study*, 6 ISR. J. HEALTH POL'Y RES. 57, 58 (2017). In a study conducted by one of the authors of this article, the author found that a significant portion of psychiatrists in Israel indeed believe that legal representation increases the likelihood of recurrent hospitalizations and negatively impacts the relationship between the caregiver and the individual with a mental

Some Members of Knesset, however, supported the idea of granting mandatory legal representation for individuals with mental disorders. In the end, it was decided to amend the law to provide for legal representation under the Opt-In model (requiring the patient's consent as a condition for obtaining the right) rather than imposing Mandatory Representation.[123] Section 29A of the law stipulates that when a case involving an individual with a mental disorder is brought before the Board, that individual shall be entitled to state-provided legal representation.[124]

Accordingly, the right to legal representation in Israel in involuntary hospitalization proceedings is based on several key elements.[125] First, the law grants the right to legal representation both at hearings before the DPB and in appeals of DPB decisions before a court.[126] Yet, it does not establish a right to representation in the initial stages, such as the issuance of a hospitalization order or an initial examination order. Second, the right to legal representation is state-funded and not contingent on the financial situation of individuals with mental disorders or the likelihood of their request to avoid involuntary hospitalization being granted.[127] Third, the representation must be adequate.[128] Fourth, individuals with mental disorders have the right to refuse representation.[129] In such cases, the refusal must be brought to the attention of the DPB, which is authorized to examine the circumstances of the refusal.[130] The law does not explicitly address situations in which it is impossible to ascertain why an individual refused representation.[131] One

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health condition. The authors emphasize that none of these claims have been empirically tested.

[123] Raskin et al., *supra* note 122.

[124] *See* § 29, Mental Health Act, 2004 (Isr.) ("(a) In a hearing before a District Psychiatric Board and in an appeal against its decisions, the patient may be represented by an attorney. (b) If the patient is hospitalized pursuant to a hospitalization order or is under outpatient treatment pursuant to an outpatient treatment order, they are entitled to be represented in the aforementioned hearing under subsection (a) by an attorney appointed to provide legal services under the provisions of the Legal Aid Law, 1972 . . . . (e) If a patient requests to be represented by an attorney under this section, or if their guardian or a relative, when the patient's opinion cannot be ascertained, requests that the patient be represented, the patient shall be given the opportunity to meet with the attorney in a manner that enables proper legal representation."). *See also* Argo et al., *supra* note 119.

[125] *Id.*

[126] *Id.*

[127] *Id.*

[128] *Id.*

[129] *Id.*

[130] *See* § 7, Mental Health Regulations (Legal Representation in Compulsory Treatment), 2006 (Isr.).

[131] *Id.*

Israeli court has ruled that in such a case, it is advisable for the DPB to order the appointment of legal representation.[132]

The legal representation procedure begins shortly after the individual is admitted for involuntary hospitalization. At this stage, the department director explains to the individuals their right to legal representation and provides a form outlining this right. After receiving the explanation, the individual signs the form confirming receipt.[133] If the individual refuses representation, the department director must record this on the form and specify the reasons for the refusal.[134]

If individuals with mental disorders request to be represented by an attorney, the management of the medical institution where they are hospitalized must grant them the opportunity to meet with an attorney under conditions that enable adequate legal representation.[135] Signing the information form does not constitute the formal appointment of a legal representative but merely an expression of willingness to meet with an attorney. In practice, representation is provided only when the individuals confirm their desire for representation directly to the attorney. An exception to this rule applies when a hearing is held about extending hospitalization beyond 14 days. In such cases, individuals may meet with an attorney even if they have not explicitly requested representation—unless they expressly refuse to meet with an attorney.[136] If an individual refuses representation, the refusal must be brought before the DPB, which will then decide whether to grant legal assistance.[137]

When individuals request representation, they must sign a power of attorney appointing the attorney as their legal representative, together with a medical confidentiality waiver form.[138] This waiver allows the attorney to

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132 AdmA (DC Hi) 527/08 Anonymous v. Dist. Psychiatrist, Haifa & N. Dist. (2008) (Isr.).

133 § 3(a), Mental Health Regulations (Legal Representation in Compulsory Treatment), 2006 (Isr.) (stating "[u]pon the admission of a patient to compulsory treatment within a treatment facility, the director shall provide the patient with a form, as set out in Form 2 of the Schedule, detailing the right to legal representation, and shall explain to the patient the right to legal representation, the content of the form, and the means of contacting the person responsible for legal representation.").

134 *Id.*

135 § 5, Mental Health Regulations (Legal Representation in Compulsory Treatment) 2006 (Isr.).

136 *See* § 24, Mental Health Act, 2004 (Isr.).

137 AdmA (DC TA) 689/98 Anonymous v. District Psychiatric Board, PM 5758(3) 145 (1998) (Isr.).

138 The requirement to sign a power of attorney and a confidentiality waiver form is not explicitly mandated by law but is inferred from Section 91 of the Bar Association Law and the Patients' Rights Law. § 91, Bar Ass'n Act, 5721–1961 (Isr.),

obtain copies of the individual's medical records. During the DPB hearing, the attorney may present evidence on behalf of the individual with a mental disorder and cross-examine the treating psychiatrist and other participants at the hearing, including social workers, neighbors, and family members.[139] According to periodic data published by the Israeli Ministry of Justice, approximately 90% of individuals with mental disorders who are involuntarily hospitalized and whose cases are brought before the DPB are represented by an attorney.[140]

In conclusion, the right to legal representation under the Opt-In model for involuntarily hospitalized individuals with mental disorders has brought about a significant change, with a substantial increase in the rate of representation before the DPBs. Yet, a segment of hospitalized individuals still does not exercise this right. This raises important questions about the possibility of transitioning to a more effective model. This question becomes even more relevant to the demonstrated advantages of legal representation, as discussed above and as reflected in the findings of our research in the subsequent sections of this Article.

IV. THE CIVIL INVOLUNTARY COMMITMENT PROCESS IN THE UNITED STATES

This Section examines the legal framework governing civil involuntary commitment in the U.S., with a specific focus on the right to legal representation. The discussion proceeds in four parts. Part One provides a general overview of the involuntary commitment process, from the initial petition to the issuance of a commitment order. Part Two outlines the hearing process, emphasizing the procedural rights afforded to individuals, including the right to contest the hospitalization. Part Three explores the legal right to counsel, reviewing both statutory provisions and landmark judicial decisions that have shaped this right. This part also addresses the scope of the attorney's role and analyzes the waiver of representation, including the heightened standards applied to ensure informed and voluntary waivers. Part Four concludes with a comparative assessment of the American and Israeli

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https://rotenberglaw.co.il/_Uploads/dbsAttachedFiles/The_Bar_Association_Act_june_2015.prd [https://perma.cc/U3SQ-BXLB]. These laws prohibit the disclosure of information to a third party without the patient's consent, thereby necessitating such documentation to authorize legal representation and information sharing. *Id.*

139 *See* § 24 Mental Health Act, 2004 (Isr.).

140 *See* Ministry of Justice (Isr.), Report on Legal Representation in Involuntary Hospitalization Proceedings (2022), https://www.gov.il/he/pages/report_210823 [in Hebrew].

models, highlighting the benefits and limitations of each system and identifying key considerations for future legal reforms.

A. The Commitment Process: An Overview

Civil involuntary commitment refers to the legal proceeding in which the state seeks to hospitalize an individual against their will for the purpose of receiving psychiatric treatment in a mental health facility. In the U.S., as in Israel, involuntary hospitalization requires a detailed and formal procedure. The process begins with the submission of medical evidence to the court indicating that an individual has a mental illness and poses a danger to themselves or others. In most states, at least two such pieces of evidence are required, one of which may come from a psychologist or another medical professional. However, a few states allow the process to be initiated based on a single piece of medical evidence.

The commitment process, primarily aimed at isolating and removing the individual from society rather than providing medical treatment, begins when an interested party—such as a family member,[141] friend, or, in some cases, law enforcement—submits a request to a hospital to have an individual involuntarily committed. [142] Generally, the medical evidence is presented in the form of an affidavit or certification submitted by a psychiatrist to the court.[143] The petition must include evidence that the individual poses a danger to themselves or others or lacks the basic ability to care for their fundamental needs. The hospital psychiatrist is then required to verify whether the conditions for involuntary commitment are met, and if so, they may authorize the hospitalization.[144]

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141 *In re* Wollan, 390 N.W.2d 839, 843 (Minn. Ct. App. 1986) (granting the right of family members as "interested persons" in mental health commitment and release proceedings).

142 McKinney v. George, 556 F.Supp. 645, 648–50 (N.D. Ill. 1983) (stating that probable cause that allows police officer to arrest an individual is sufficient to initiate involuntary civil commitment process where officer could reasonably believe individual's actions "might injure himself or others")). For additional information on the lack of requirement that notice under oath be given when a police officer apprehends an individual under such circumstances, *see, e.g.,* State v. Lee, 846 P.2d 424 (Or. Ct. App.1993).

143 *See generally* MICHEL L. PERLIN & HEATHER ELISS CUCOLO, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL (3d ed. 2017) (providing a comprehensive doctrinal and theoretical overview of civil and criminal mental disability law).

144 Clifford D. Stromberg & Alan A. Stone*, A Model State Law on Civil Commitment of the Mentally Ill*, 20 HARV. J. ON LEGIS. 275, 321 (1983).

B. The Hearing Process

In all forms of commitment, the hospitalized individual has the right to present arguments against the legality or necessity of their hospitalization.[145] Besides South Dakota,[146] all U.S. states require the hearing to be held before a judge.[147] Involuntary hospitalization cannot proceed without a hearing. In emergency cases, although the individual may be hospitalized immediately, the law requires a hearing to take place as soon as possible—and in any case, no later than ten days from the date of hospitalization.[148]

The hearing process grants the individual numerous procedural rights, including the right to receive notice, to be present at the legal proceedings, to a jury trial, to cross-examine witnesses, and to present an independent expert opinion. Additionally, they have the right to legal representation.[149] The purpose of the hearing is to examine both the legality of the commitment process and the necessity of involuntary hospitalization. Because this process

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145 *Developments in the Law—Civil Commitment of the Mentally Ill,* 87 HARV. L. REV. 1190, 1265–71 (1974).

146 S.D. CODIFIED LAWS § 27A-10-14 (2023) ("Within ninety days after the involuntary commitment of a person who is still under the commitment order, the county board of mental illness which serves the county in which the person is receiving treatment shall conduct a review hearing in the county to determine if the person continues to meet the criteria in § 27A-10-9.1 . . . . If the person has not retained counsel at the time of the notice, the chair of the county board shall immediately appoint counsel to represent the person."). *See also* Michael J. Ferlauto & Richard L. Frierson, *The Probate Judge and Involuntary Civil Commitment in South Carolina*, 39 J. AM. ACAD. PSYCHIATRY L. 209, 213 (2011) ("A published report of consecutive commitment hearings in California revealed that detainees were more likely to be released if the judge had a formal legal education."); Grant H. Morris, *Civil Commitment Decisionmaking: A Report on One Decisionmaker's Experience*, 61 S. CAL. L. REV. 291, 295 (1988) ("While the court did not mandate a judicial hearing, it required that the hearing be conducted by a person or group of persons independent of the mental health facility.").

147 John J. Brunetti, *The Right to Counsel, Waiver Thereof, and Effective Assistance of Counsel in Civil Commitment Proceedings*, 29 SW. L.J. 684, 701 (1975).

148 Stamus v. Leonhardt, 414 F. Supp. 439, 446 (S.D. Iowa 1976) (stating if a hearing is not feasible before an individual is taken into custody, it should be held "shortly thereafter"); French v. Blackburn, 428 F. Supp. 1351, 1355 (M.D. N.C. 1977) (upholding the constitutionality of a North Carolina statute that provided for a final hearing within ten days of confinement that the U.S. Supreme Court later summarily affirmed); Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES 37, 39 (1999) ("An influential case was the three-judge federal district court decision in *Lessard v. Schmidt*, which required various procedural formalities at the involuntary hospitalization hearing."); Christyne E. Ferris, *The Search for Due Process in Civil Commitment Hearings: How Procedural Realities Have Altered Substantive Standards*, 61 Vand. L. Rev. 959, 968 (2008).

149 Bradley D. McGraw et al., *Civil Commitment in New York City: An Analysis of Practice*, 5 PACE L. REV. 259, 282 (1985) (listing the right emerged from the right to due process).

may result in the deprivation of liberty, it has been established that a hearing is mandatory and can be waived only in exceptional circumstances.[150]

In such exceptional cases, the court must be convinced that the waiver was freely given or that the waiver was signed following consultation with an attorney.[151] If the court approves the involuntary commitment, the individual has the right to periodic review hearings to determine whether the conditions for continued hospitalization are still met. In these hearings, as in the initial hearing, the hospitalized individual is entitled to legal representation.[152]

C. The Right to Legal Representation

Legal representation plays a pivotal role in safeguarding the rights and dignity of individuals subject to involuntary psychiatric hospitalization. This section examines the legal and constitutional foundations of the right to counsel in the U.S., the evolving role of attorneys in commitment proceedings, and the complex question of whether and under what conditions this right may be waived. First, we trace the development of the right to legal representation in U.S. constitutional and statutory law. Next, we analyze the professional standards and ethical duties of attorneys representing individuals facing involuntary hospitalization. Finally, we explore the circumstances under which individuals may waive their right to legal counsel and the legal limitations on such waivers, with particular attention to the unique challenges posed by mental illness.

1. The Legal and Constitutional Right to Legal Representation

Today, the laws of all U.S. states recognize the right to legal representation in involuntary commitment proceedings.[153] This recognition developed from the 1980s onward, following the expansion of the right to representation in criminal proceedings and its extension to civil

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[150] Kirsten E. Lundergan, Comment, *The Right to Be Present: Should It Apply to the Involuntary Civil Commitment Hearing*, 17 N.M. L. REV. 165, 166 (1987); Samantha M. Caspar & Artem M. Joukov, *Worse than Punishment: How the Involuntary Commitment of Persons with Mental Illness Violates the United States Constitution*, 47 HASTINGS CONST. L.Q. 499, 508 (2020); Ferris, *supra* note 148, at 968; Anfang & Appelbaum, *supra* note 9, at 218.

[151] *See generally* Lundergan, *supra* note 150, at 166; Caspar & Joukov, *supra* note 150, at 508; Ferris, *supra* note 148, at 968; Anfang & Appelbaum, *supra* note 9, at 218.

[152] *See* sources cited *supra* note 148.

[153] *See* Simei Zhang et al., *Involuntary Admission and Treatment of Patients with Mental Disorder*, 31 NEUROSCIENCE BULL. 99, 106 TBL.5 (2015); Margaret J. Lederer, *Not So Civil Commitment: A Proposal for Statutory Reform Grounded in Procedural Justice*, 72 DUKE L.J. 903, 910 (2023) (analyzing procedural safeguards including right to counsel under U.S. civil commitment regimes).

proceedings.[154] In 1932, in *Powell v. Alabama*, the U.S. Supreme Court ruled that "[t]he right to be heard would be . . . of little avail if it did not comprehend the right to be heard by counsel." [155] This case concerned African American defendants who were charged with rape and sentenced to death after being denied adequate legal representation.[156] The Court emphasized that the state must appoint an attorney in serious cases where the defendant's life and liberty are at significant risk, recognizing that legal representation is essential to ensuring a fair trial. [157]A decade later, in *Johnson v. Zerbst*, the Court reinforced the importance of legal representation, holding that an attorney serves as a gatekeeper for constitutional rights under the Fourteenth Amendment, ensuring the protection of human rights to life and liberty. However, this right was initially limited to felony cases.[158]

The 1963 ruling in *Gideon v. Wainwright* marked a turning point in the expansion of the right to counsel.[159] Clarence Gideon, charged with the felony offense of burglary, was denied legal representation because, under Florida law at the time, court-appointed counsel was provided only in capital cases. Following his conviction, Gideon appealed to the U.S. Supreme Court, which held that under the Sixth and Fourteenth Amendments, an attorney must be appointed for any indigent defendant charged with a serious criminal offense. [160] The Court reasoned that legal representation is essential to

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[154] *See generally* Walter R. Gove et al., *Involuntary Psychiatric Hospitalization: A Review of the Statutes Regulating the Social Control of the Mentally Ill*, 6 DEVIANT BEHAV. 287 (1985) (exploring the evolution of involuntary mental commitment proceedings). The author reviews the legal framework in the United States prior to the 1980s. *Id.* In the 1970s, all states except eight granted a statutory right to legal representation, whereas in the 1960s, only ten states provided legal representation in cases of involuntary hospitalization. *Id.* at 306, 295. Twelve states recognized the right but conditioned it on a request by the hospitalized individual (similar to the system in Israel). *Id.* at 295. Thirteen states left the decision to the discretion of the court, and in the remaining states, there was no statutory right to representation. *Id.*

[155] Powell v. State of Ala., 287 U.S. 45, 69 (1932) (emphasis added).

[156] *See id.* at 49.

[157] *See id.* at 72–73.

[158] *See* Johnson v. Zerbst, 304 U.S. 458, 462 (1938). (The assistance of counsel is "one of the safeguards of the Sixth Amendment deemed necessary to insure fundamental human rights of life and liberty.").

[159] *See* Stanley S. Herr, *The New Clients: Legal Services for Mentally Retarded Persons*, 31 STAN. L. REV. 553 (1979) (noting that, as of that time, only two states required the court to appoint an attorney for individuals with mental illness in cases of civil involuntary hospitalization); Sara Mayeux, *What* Gideon *Did*, 116 COLUM. L. REV. 15 (2016) (discussing the doctrinal and institutional changes triggered by *Gideon*).

[160] Gideon v. Wainright, 372 U.S. 335, 343 (1963).

protect individual liberty and ensure the fairness of criminal proceedings whenever the deprivation of liberty is at stake.[161]

Another landmark ruling that expanded the right to representation was *In re Gault*.[162] This case involved a juvenile who was arrested for making an inappropriate phone call to a neighbor. His parents were not notified of his arrest, and he was tried without legal counsel. The Supreme Court overturned the ruling and broadened the interpretation of the Sixth Amendment, establishing that the right to due process applies not only to criminal proceedings but also to civil proceedings that may result in the deprivation of liberty, such as involuntary hospitalization.[163] This case laid the foundation for extending the right to legal representation in civil proceedings.

The recognition of the right to representation in civil proceedings culminated in *Lessard v. Schmidt*.[164] This case concerned Ms. Lessard, who was involuntarily hospitalized after being found wandering the streets, despite not posing an immediate danger to herself or others. The court ruled that all individuals facing involuntary hospitalization were entitled to legal representation and that if they could not afford an attorney, the state must appoint one. The decision also addressed the need to appoint an independent attorney in cases where an individual had a legal guardian. Whereas the guardian's role is to act in the best interests of the individual, at times disregarding the individual's wishes, the lawyer's role is to represent the individual's expressed will. Thus, even individuals with a guardian must be assigned an attorney to ensure their voice is heard.[165] Following *Lessard*, the

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[161] Gove et al., *supra* note 154; Hiday & Goodman, *supra* note 108. Gideon, 372 U.S. at 344–45 (holding that the right to counsel is fundamental to protecting individual liberty and ensuring fairness in criminal proceedings); *see* NICHOLAS N. KITTRIE, THE RIGHT TO BE DIFFERENT: DEVIANCE AND ENFORCED THERAPY (1971) (discussing broader themes of deviance, liberty, and state intervention).

[162] *In re* Gault, 387 U.S. 1, 50 (1967) ("It is incarceration against one's will, whether it is called 'criminal' or 'civil.' And our Constitution guarantees that no person shall be 'compelled' to be a witness against himself when he is threatened with deprivation of his liberty . . . .").

[163] *Id.*

[164] Lessard v. Schmidt, 349 F.Supp. 1078, 1097–98 (E.D. Wis. 1972) (asserting that a person detained on grounds of mental illness has a right to counsel, and to appointed counsel if the individual is indigent). *See also* Thomas K. Zander, *Civil Commitment in Wisconsin: The Impact of Lessard v. Schmidt*, 1976 WIS. L.REV. 503, 514 (1976) (analyzing the effect of Lessard v. Schmidt on Wisconsin's civil commitment laws, particularly regarding procedural safeguards and patients' constitutional rights). *See generally* MICHAEL L. PERLIN & HEATHER ELLIS CUCOLO, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL Ch. (3d ed. 2017).

[165] *Lessard*, 349 F.Supp. at 1098. *See* Ferris, *supra* note 148, at 980.

right to legal representation was extended to all significant stages of involuntary commitment proceedings in all U.S. states.[166]

These landmark rulings reflect a fundamental principle: the deprivation of liberty necessitates heightened protection for individual rights. Legal representation is not only a means to ensure a just outcome but also a tool for upholding human dignity and autonomy. This legal evolution underscores that the right to representation is a substantive one in any proceeding that could infringe on fundamental liberties, including both criminal and involuntary commitment proceedings. Today, every U.S. state mandates the appointment of an attorney for individuals facing involuntary hospitalization, and requires that individuals who cannot afford representation be provided with state-appointed counsel. This firmly establishes the right to legal representation as an inalienable component of due process, safeguarding human rights to liberty and protection from arbitrary government actions.

2. The Role of the Attorney

A critical question is whether the statutory guarantee of legal representation—ensuring that every involuntarily hospitalized individual is entitled to counsel and, if unable to afford one, receives state-appointed representation—is sufficient to ensure the realization of this right. Alternatively, should additional requirements be established, such as specific qualifications and professional standards for attorneys, to guarantee effective representation? Some states have addressed this issue through legislation, and others have done so through judicial rulings.

Most U.S. states do not explicitly define the responsibilities of attorneys representing involuntarily hospitalized individuals, but some states have enacted laws outlining these duties in detail.[167] For example, in Arizona, the

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166 Lynch v. Baxley, 386 F.Supp. 378, 389 (M.D. Ala. 1974). *See also* Jack Drake, *Drafting the Case: The Parallel Legacies of* Wyatt v. Stickney *and* Lynch v. Baxley, 35 L. & PSYCH. REV. 167, 171 (2011) (discussing how *Lessard v. Schmidt* established the right to legal representation at all "significant stages" of civil commitment proceedings).

167 James R. Elkins, *Legal Representation of the Mentally Ill*, 82 W. VA. L. REV. 157, 158 (1979) (citing John J. Brunetti, *The Right to Counsel, Waiver Thereof, and Effective Assistance of Counsel in Civil Commitment Proceedings*, 29 SW. L.J. 684, 689 n.21 (1975)). Elkins divides the rules into six different categories: (1) Provisions stating that the right to representation exists; (2) Provisions stating that the right to representation exists and providing representation if the individual is indigent; (3) Provisions stating that the right to representation exists, providing representation if the individual is indigent, and establishing a timeframe for representation; (4) Provisions stating that the right to representation exists, providing representation if the individual is indigent, and specifying the role of the attorney in such cases; (5) Provisions stating that the right to representation exists and extending it to different stages of the involuntary hospitalization process; and (6) Provisions stating that the right to representation exists and, in addition, establishing an organized system to provide this service or allowing for the

law mandates the immediate appointment of an attorney upon the initiation of commitment proceedings.[168] The attorney must explain individuals' rights, including their right to publicly funded representation if they cannot afford private counsel, and inform them of their option to retain private counsel.[169]

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establishment of such a system. Examples of this can be found in the laws of Montana and Colorado. Mont. Code. Ann. § 53-21-116 (2022), pointing out that "[T]he person alleged to be suffering from a mental disorder and requiring commitment has the right to be present and the right to counsel at any hearing or trial." If the person is indigent or if in the court's discretion assignment of counsel is in the best interest of justice, the judge must order the office of state public defender, provided for in MONT. CODE. ANN. § 2-15-1029, to immediately assign counsel to represent the person at either the hearing or the trial, or both. COLO. REV. STAT. ANN. § 27-65-127 (West 2025). Whenever any proceedings are instituted or conducted pursuant to this section, the following procedures apply:

> (a) Upon the filing of a petition, the court shall appoint an attorney to represent the respondent. The respondent may replace the attorney with an attorney of the respondent's own choosing at any time. Attorney fees for an indigent respondent are paid by the court. (b) The court, upon request of an indigent respondent or the respondent's attorney, shall appoint, at the court's expense, one or more professional persons of the respondent's choosing to assist the respondent in the preparation of the respondent's case.

D.C. CODE. ANN. § 21-543 (West 2001). D.C.'s statute requires that if the respondent fails or refuses to obtain counsel, the court shall appoint counsel to represent them. The counsel so appointed shall be awarded compensation by the court for his services in an amount determined by it to be fair and reasonable. The compensation shall be charged against the estate of the individual for whom the counsel was appointed, or against any unobligated funds of the Commission, as the court in its discretion directs.

[168] ARIZ. REV. STAT. ANN. § 36-540 (2024).

[169] ARIZ. REV. STAT. ANN. § 36-537B (2010).

> The patient's attorney, for all hearings, whether for evaluation or treatment, shall fulfill the following minimal duties:
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> 1. Within twenty-four hours of appointment, conduct an interview of the patient. The attorney shall explain to the patient the patient's rights pending court-ordered treatment, the procedures leading to court-ordered treatment, the standards for court-ordered treatment, the alternative of becoming a voluntary patient and whether stipulations at the hearing are appropriate. If the attorney is appointed, the attorney also shall explain that the patient can obtain the patient's own counsel at the patient's own expense and that, if it is later determined that the person is not indigent, the person will be responsible for the fees of the appointed attorney for services rendered after the initial attorney-client conference.
>
> 2. At least twenty-four hours before the hearing, review the petition for evaluation, prepetition screening report, evaluation report, petition for treatment, the patient's medical records and the list of alternatives to court-ordered treatment.
>
> 3. At least twenty-four hours before the hearing, interview the petitioner, if available, and the petitioner's supporting witnesses, if known and available.

The attorney is also required to review the petition and medical records at least 24 hours before the hearing, summon relevant witnesses, and obtain an independent medical opinion if necessary. These requirements ensure that individuals with mental disorders receive adequate representation and that all pertinent information is presented to the board.

In Minnesota, the law goes further, requiring attorneys to address complex ethical issues.s 'Attorneys must act according to the individual [170] expressed wishes, even if they conflict with medical recommendations or are perceived as suboptimal by treating professionals. The attorney's role is to protect the individual's autonomy and ensure that their voice is heard, even if their desires conflict with what is considered to be in their "best interest." This approach reflects the commitment of the state to respecting individual autonomy and ensuring independent decision-making in involuntary hospitalization proceedings.[171]

In New York, an additional element of cognitive competency assessment is incorporated into the attorney's role, who must ensure that individuals with a mental disorder comprehend the legal proceedings and their rights and assess whether they are capable of participating in the process with full awareness. [172] If individuals seek to waive legal representation, the attorney is required to present the request to the DPB but must continue to provide representation unless it is proven that the individuals fully understand the consequences of waiving their rights.[173]

In Texas, the law focuses on the procedural rights of individuals with mental disorders and requires the attorney to ensure compliance with legal procedures.[174] The attorney must object to any procedural deviations, summon witnesses on behalf of the individual, and thoroughly review all

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> 4. At least twenty-four hours before the hearing, interview the physicians or the psychiatric and mental health nurse practitioner who will testify at the hearing, if available, and investigate the possibility of alternatives to court-ordered treatment.
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> C. Failure of the attorney to fulfill at least the duties prescribed by subsection B may be punished as contempt of court.
>
> D. At a hearing held pursuant to this article, the patient's attorney may enter stipulations on behalf of the patient.

Id.

[170] MINN. STAT. ANN. 253B.07 (2c) (2024).

[171] *Id.*

[172] N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2025).

[173] *Id.*

[174] TEX. HEALTH & SAFETY CODE ANN. § 574.105 (West 1995).

medical records that could support the client's claims.[175] If a decision is made contrary to the individual's wishes, the attorney is obligated to file an appeal to ensure that every judicial ruling is well-founded and justified.

California presents a different model, in which the attorney guides the individual not only during the hearing but also throughout the entire hospitalization.[176] The attorney remains involved even after a decision has been made to continue treatment, particularly when outpatient treatment orders are issued.[177] This approach ensures continuous legal representation, protecting the individual throughout the process, not only during the initial legal proceedings.

These examples illustrate differences across U.S. states regarding legal representation in involuntary commitment proceedings. Some states, like Arizona, stress early preparation by attorneys and ensure adequate representation from the start of the process. Others, such as Minnesota and New York, prioritize safeguarding the autonomy of individuals with mental disorders and assessing their cognitive competence to participate in legal proceedings. California offers a model focusing on ongoing legal support, and Texas underscores the importance of procedural integrity in commitment hearings.

These variations reflect the diverse approaches taken in the U.S. to balance individual autonomy and rights with the protection and well-being of individuals with mental disorders. Some states prioritize strict procedural compliance and professional legal representation throughout the process; others focus on empowering individuals and preserving their right to choose their preferred course of action. These approaches illustrate the complexity of ensuring a fair and respectful legal process for involuntarily hospitalized individuals while accommodating their unique medical and legal needs.

Judicial rulings by state supreme courts have also played a significant role in shaping attorneys' responsibilities in this field. Although the U.S. Supreme Court has not directly addressed this issue, the ruling of the Montana Supreme Court in *K.G.F.*[178] is considered one of the most influential

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[175] *Id.*

[176] CAL. WELF. & INST. CODE § 5250 (West 2025).

[177] *Id.*

[178] *In re* Mental Health of K.G.F., 29 P.3d 485 (Mont. 2001), *overruled by In re* J.S., 401 P.3d. 197, (Mont. 2017). *In re* J.S., 401 P.3d 197, 202–05 (Mont. 2017) (overruling *In re K.G.F.* only with respect to the standard of proof, holding that "clear and convincing evidence" rather than "beyond a reasonable doubt" is required in involuntary commitment proceedings, while leaving intact *K.G.F.'s* holding on the right to effective assistance of counsel).

decisions on the topic by some legal scholars.[179] This case concerned the professional competence of attorneys representing involuntarily committed individuals. The court ruled that effective legal representation requires attorneys to take several essential actions, including: (1) meet with the client and explain the nature of the proceedings and the anticipated legal process; (2) review medical records and the client's psychiatric history; (3) present witnesses and evidence supporting the client's request for release; (4) familiarize themselves with the opposing side's arguments and witnesses; and (5) investigate the client's relationships with their close environment.

The significance of *K.G.F.* lies in its emphasis on the need for clear professional standards for attorneys in involuntary commitment proceedings. [180] Attorneys are required not only to act in what external parties perceive as the individual's best interest but to advocate for the client's expressed wishes. Effective legal representation ensures not only the fairness of the process but also empowers individuals with mental disorders, enabling them to participate in legal proceedings and express their wishes fully.

3. Waiver of the Right to Legal Representation in Involuntary Commitment Proceedings

Despite the recognition that the right to legal representation in involuntary commitment proceedings derives from both the U.S. Constitution and state laws, and of the clear advantages of having legal counsel, a fundamental question arises: is this right non-waivable, and if it can be waived, what conditions must be met for such a waiver to be valid? There is no uniform standard in the U.S. regarding the right to waive legal representation. With the exception of Montana,[181] all states allow individuals to waive legal representation, but a court must approve such waivers.[182]

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[179] *See, e.g.*, Michael L. Perlin, *"I Might Need a Good Lawyer, Could Be Your Funeral, My Trial": Global Clinical Legal Education and the Right to Counsel in Civil Commitment Cases*, 28 WASH .U. J.L. & POL'Y 241, 245 (2008).

[180] *See In re* J.S., 401 P.3d 197, 205 (Mont. 2017) (clarifying that although the court overruled the standard set forth in *K.G.F.* for evaluating the effectiveness of counsel, the statutory and constitutional basis for the right to effective assistance of counsel in civil commitment proceedings, as well as the emphasis on professional standards and due process of law, remains intact).

[181] *In re* J.S., 401 P.3d. at 202 (noting that the legislature expressly provided that right to counsel may not be waived). MONT. CODE ANN. § 53-21-119 (2023) (providing that "[t]he right to counsel may not be waived. The right to treatment provided for in this part may not be waived."); S.B. 435, 68TH LEG., REG. SESS. § 12(1) (Mont. 2025) (codified at MONT. CODE ANN. § 53-21-119) (clarifying in even more explicit terms that "[a] respondent's right to counsel and the right to treatment provided for in this part may not be waived.").

[182] *See, e.g.*, State v. Ritzman, 84 P.3d 1129, 1129 (Or. 2004) ("[A] trial court in a civil commitment proceeding must either advise the allegedly mentally ill person directly regarding

According to precedent established by the U.S. Supreme Court in *Faretta v. California*, a court must ensure that the waiver is "made knowingly, intelligently, and voluntarily . . . ."[183] To meet this standard, the judge must review medical records, speak with the individual, explain the risks and disadvantages of self-representation, and assess whether the decision is made with full awareness. If the waiver does not meet these criteria, it will be deemed invalid, and the court will be required to appoint legal counsel for the individual.[184]

The *Faretta* decision created a constitutional foundation for the right to self-representation,[185] but it faced significant criticism.[186] Critics argued that the ruling prioritized personal autonomy over legal fairness, raising concerns that unrepresented individuals might inadvertently harm their legal interests.[187] The question of whether this right extends to individuals with

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those rights or conduct an examination on the record to determine whether a valid waiver of the right to be advised has been knowingly and voluntarily made.").

183 United States. v. Hall, 610 F.3d 727, 739 (D.C. Cir. 2010) (holding that the right to counsel may be knowingly and intelligently waived regardless of defendant's lawyering skills and experience); *In re* R.Z., 415 N.W.2d 486, 488 (N.D. 1987) (stating that North Dakota relies on criminal cases "to define the rights of respondents in mental health proceedings" and that a respondent may waive counsel if the waiver is "knowing and intelligent and voluntary"). *See generally* Faretta v. California, 422 U.S. 806, n.15 (1975) (explaining that the right to self-representation is grounded in personal autonomy and individual dignity).

184 McDuffie v. Berzzarins, 330 N.E.2d 667, 668–69 (Ohio 1975) (explaining waiver of one's constitutional right to counsel is not valid where there is no showing that the individual knew of his right to counsel).

185 *Faretta*, 422 U.S. at 835 ("This Court has often recognized the constitutional stature of rights that, though not literally expressed in the document, are essential to due process of law in a fair adversary process.").

186 Kathryn E. Miller, *The Myth of Autonomy Rights*, 43 CARDOZO L. REV. 375, 377–91 (2022); Martin Sabelli & Stacey Leyton, *Train Wrecks and Freeway Crashes: An Argument for Fairness and Against Self Representation in the Criminal Justice System*, 91 J. CRIM. L. & CRIMINOLOGY 161, 163–75 (2001) (arguing that a focus on defendant autonomy can undermine commitments to justice and the adversarial process); *see generally* William Bradley Wendel, *Autonomy Isn't Everything: Some Cautionary Notes on McCoy v. Louisiana*, 9 ST. MARY'S J. ON LEGAL MALPRACTICE & ETHICS 92, 126–36 (2018) (questioning whether McCoy protected defendant autonomy at the cost of sacrificing reliability and fairness); Robert E. Toone, *The Incoherence of Defendant Autonomy*, 83 N.C. L. REV. 621, 623 (2005) (finding that *Faretta's* emphasis on autonomy "sidesteps more difficult questions about inequality and injustice in the criminal justice system, the proper allocation of authority between attorneys and clients, and other structural problems."); *see generally* John F. Decker, *The Sixth Amendment Right to Shoot Oneself in the Foot: An Assessment of the Guarantee of Self-Representation Twenty Years After Faretta*, 6 SETON HALL CONSET. L.J. 483, 485–90 (1996).

187 United States. v. Veltman, 9 F.3d. 718, 719 (8th Cir. 1993); *In re* S.Y., 469 N.W.2d 836, 841 (1991) (stating the genuine waiver of counsel in involuntary-commitment proceedings involves a deliberate choice to proceed without counsel and a subjective awareness of the risks and hazards of proceeding to trial without counsel).

mental disorders was later addressed in *Godinez v. Moran* and *Indiana v. Edwards.*[188]

In *Godinez*, an individual with a mental disorder sought to dismiss his attorney and plead guilty. [189]The Supreme Court ruled that because he was deemed competent to stand trial, he was also competent to waive legal representation. The Court established that the competence standard for standing trial applies equally to the competence required for waiving legal representation.[190]

The *Edwards* ruling limited the precedent set in *Godinez*. In *Edwards*, an individual was found competent to stand trial but sought to represent himself.[191] The Supreme Court held that competence to stand trial does not automatically equate to competence to represent oneself.[192] The justices noted that mental illnesses may impair people's ability to represent themselves adequately even if they are legally fit to stand trial. The Court rejected Indiana's proposed "coherent communication" test, which would have required the individual to communicate coherently with the court or jury, and instead ruled that courts must assess the defendants' mental ability to represent themselves without requiring technical legal knowledge.[193]

The *Edwards* ruling effectively created a higher competence standard for self-representation than for standing trial. As a result, some individuals may be deemed competent to stand trial but not to represent themselves because of their mental illness. The Supreme Court reasoned that self-representation

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[188] Godinez v. Moran, 509 U.S. 389, 400 (1993); Indiana v. Edwards, 554 U.S. 164, 169 (2008).

[189] *Godinez*, 509 U.S. at 389.

[190] *Id.* at 390–91. The legal test "communicate coherently with the court or a jury" refers to a person's ability to communicate clearly and coherently with the court or the jury, as part of the assessment of their legal competence. *Edwards,* 554 U.S. at 177. This test is primarily used in legal systems such as that of the United States, in the context of determining a defendant's competency to stand trial. The test is based on two main components: (1) the ability to understand legal proceedings, meaning whether the individual comprehends the roles of the judge, prosecutor, and defense attorney, as well as the nature of the charges against them; and (2) the ability to assist in their defense, meaning whether the individual can communicate with their attorney in a rational and coherent manner to ensure the proper conduct of the defense in court. This test is part of the standards established in American case law, particularly in the ruling of *Dusky v. United States*, which determined that, for a person to be deemed competent to stand trial, they must have a sufficient understanding of the proceedings against them and be able to communicate rationally with their attorney. Dusky v. United States, 462 U.S. 402, 402 (1960). The standard of "communicate coherently" may be incorporated into competency assessments in cases where there is doubt regarding the individual's ability to understand the proceedings or actively participate in them. *Id.*

[191] *Edwards*, 554 U.S. at 165.

[192] *Id.*

[193] *Id.*

under such conditions could undermine individuals' right to a fair trial even if it reflects their personal choice.[194]

The Court based its decision on three key principles. First, the right to self-representation, which is intended to protect personal autonomy and dignity, fails to serve its purpose when individuals' mental state prevents them from adequately advocating for themselves.[195] Second, mental illnesses can impair cognitive and behavioral abilities in various ways. Although a mental disorder may not affect people's competence to stand trial, it could impair their ability to present clear, coherent, and structured arguments.[196] Third, the public interest requires that legal proceedings be fair and that professional representation is necessary to prevent wrongful convictions and unjust legal outcomes.[197] Nevertheless, the Court clarified that mental illness alone is not sufficient to deny individuals the right to self-representation. Courts must individually assess how the condition affects their ability to manage their legal affairs.[198]

In its ruling, the Supreme Court noted that granting self-representation rights to individuals incapable of handling their case harms not only their right to a fair trial but also their dignity and autonomy—the very rights that self-representation was meant to protect. Instead of empowering individuals, it might jeopardize their legal rights and lead to unjust judicial decisions. The Court warned that allowing self-representation in these cases could result in individuals being involuntarily hospitalized or treated under unlawful conditions simply because they lacked the capacity to properly navigate the legal process. [199] This ruling reveals a conflict between two constitutional rights: an individual's autonomy to waive legal representation and their right to a fair trial, which protects their legal interests when clients are unable to represent themselves effectively.

Yet the Supreme Court did not specify a precise standard for assessing an individual's competence to self-represent. Instead, it established only broad guidelines: at one extreme, *Faretta*'s minimal competence requirement, which demands only that the individual be competent to stand trial, and at the other, a less stringent alternative to the rejected Indiana's "coherent communication" test in *Edwards*. This lack of clarity left state courts with

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194 *Id.* at 164–78.

195 *Id.* at 176–78.

196 *Id.*

197 *Edwards*, 554 U.S. at 176–78.

198 *Id.*

199 *Id.* at 177.

significant discretion to interpret competence standards independently, leading to varied judicial approaches and inconsistencies across the U.S.

Legal scholars have proposed various solutions to balance these conflicting principles without unilaterally favoring one over the other. Research on this topic indicates that, in general, unrepresented defendants experience worse legal outcomes than those with legal representational though some studies suggest no significant differences between the two groups. [200] One study compared release rates of represented and unrepresented individuals, finding no substantial differences between the groups.[201] Indeed, the study found a marginally higher release rate among unrepresented individuals, though the difference did not reach statistical significance.[202]

Despite these unexpected findings, Montana law remains strict. It does not allow waiving the right to legal representation in involuntary commitment proceedings.[203] The constitutionality of this restriction was challenged in *In re S.M.*, a landmark case addressing whether the Montana prohibition on waiving legal representation in commitment proceedings violates constitutional rights.[204]

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[200] Andrew I. Schoenholtz & Jonathan Jacobs, *The State of Asylum Representation: Ideas for Change*, 16 GEO. IMIMIGR. L.J. 739, 743 (2002) (stating that representation increased chances of asylum seekers succeeding at their hearings); Carroll Seron et al., *The Impact of Legal Counsel on Outcomes for Poor Tenants in New York City's Housing Court: Results of a Randomized Experiment*, 35 L. & SOC'Y REV. 419, 427 (2001) (finding that only 32% of represented tenants had final judgments against them, compared with 52% of tenants without legal representation); Emily S. Taylor Poppe & Jeffrey J. Rachlinski, *Do Lawyers Matter? The Effect of Legal Representation in Civil Disputes*, 43 PEPP. L. REV. 881, 943 (2016) (concluding that the evidence supports the conclusion that representation benefits clients); Rebecca L. Sandefur, *Elements of Professional Expertise: Understanding Relational and Substantive Expertise Through Lawyers' Impact*, 80 AM. SOCIO. REV. 909, 926 (2015) (presenting a meta-analysis of existing data on the effect of legal representation and concluding that lawyer representation helps especially for procedural matters.).

[201] Erica J. Hashimoto, *Defending the Right of Self-Representation: An Empirical Look at the Pro Se Felony Defendant*, 85 N.C. L. REV. 423, 428 (2007) (stating that pro se felony defendants in state courts are convicted at rates equivalent to or lower than the conviction rates of represented felony defendants, and the vast majority of pro se felony defendants–nearly 80%–did not display outward signs of mental illness).

[202] *Id.* at 450.

[203] MONT. CODE ANN. § 53-21-119(1) (2025) ("A person may waive the person's rights, or if the person is not capable of making an intentional and knowing decision, these rights may be waived by the person's counsel and friend of respondent, if a friend of respondent is appointed, acting together if a record is made of the reasons for the waiver. The right to counsel may not be waived.").

[204] *In re* S.M., 403 P.3d 324 (Mont. 2017). *Compare In re* Det. of J.S., 159 P.3d 435, 440 (Wash. Ct. App. 2007) (holding that the right to self-representation was protected by the constitution of the State of Washington and interpreting the statute to not require counsel); and *In re* S.Y., 469 N.W.2d 836, 840 (Wis. 1991) (concluding that the right to self-representation in civil commitment proceedings is protected by the constitution of the State of Wisconsin).

In *In re S.M.,* an individual with a history of mental illness was involuntarily committed to a psychiatric hospital after being deemed a danger to himself and others.[205] During the proceedings, S.M. requested to waive legal representation and represent himself before the district court.[206] On appeal, his attorneys argued that denying him this right violated his constitutional autonomy and self-representation rights, as recognized in cases like *Faretta*.[207] The court rejected this argument, ruling that in involuntary commitment cases, the primary objective is the individual's well-being rather than a punitive legal process, and thus, self-representation can be restricted.[208] The justices held that the Montana law does not violate the Constitution, as the restriction aims to protect individuals with mental disorders from harming themselves as a result of their condition.[209]

The Montana Supreme Court faced a complex legal and ethical dilemma. On the one hand, they recognized the importance of personal autonomy, a fundamental principle of individual rights, particularly when personal liberty was at stake. This principle supports recognizing an individual's right to decide whether they want legal representation. On the other hand, the justices had to consider the unique nature of involuntary commitment proceedings, which are designed to ensure appropriate medical treatment and maintain public and individual safety.[210]

The Montana Supreme Court recognized a fundamental difference between criminal and involuntary commitment proceedings.[211] In criminal cases, the primary objectives include ensuring a fair trial, deterrence, retribution, and rehabilitation. These objectives support the recognition of the right to self-representation.[212] By contrast, involuntary commitment proceedings focus on medical care and individual well-being rather than punishment or other penal goals, justifying different legal standards.

The Montana justices noted that, in many cases, individuals with mental disorders are not in a position to fully understand the complexities of legal proceedings or the risks of their decisions, such as waiving legal

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[205] *In re* S.M., 403 P.3d at 325.

[206] *Id.*

[207] *Id.* at 326; *See* Faretta v. California, 422 U.S. 806, 835 (1975).

[208] *In re S.M.*, 403 P.3d at 332.

[209] *See id.* at 330.

[210] *Id.* at 331.

[211] *See id.* at 330–31

[212] *Faretta*, 422 U.S. at 806; E. Lea Johnston, *Representational Competence: Defining the Limits of the Right to Self-Representation at Trial*, 86 NOTRE DAME L. REV. 523 (2011) (discussing constitutional limits on the right to self-representation and the balance between autonomy and trial fairness).

representation.[213] They expressed concern that allowing self-representation could jeopardize individuals' well-being and undermine their rehabilitation process. Consequently, the court upheld Montana's strict law, ruling that the prohibition on waiving legal representation in involuntary commitment proceedings was constitutional.[214] As a result, the law remains unchanged, effectively denying individuals the ability to waive legal counsel in such cases.

D. Comparative Assessment of the American and Israeli Models

Our review of the legal framework in Israel and the United States reveals that the Israeli legal model establishes the requirement that involuntarily hospitalized individuals must express their desire to exercise their right to legal representation through explicit consent. This model enhances individual autonomy, making the right to representation contingent upon the patient's request, reflecting an understanding of their situation and a deliberate choice to take legal action in response to their personal circumstances. On the other hand, the Israeli model raises concerns about its suitability for individuals involuntarily hospitalized, considering both their medical condition and the physical conditions of the closed psychiatric wards in which they are confined. These factors may impair their ability to make informed decisions or to advocate effectively for themselves. As such, the model's reliance on individual initiative to obtain legal representation may be particularly problematic in this context.

Furthermore, the Israeli law does not provide sufficient clarity regarding the possibility of waiving the right to legal representation. Therefore, it is necessary to reconsider the Israeli legal framework by either establishing Mandatory Legal Representation (granting representation without the option of waiver) or by providing clear guidelines instructing the DPB to examine the validity of a waiver (granting the right to representation but respecting an informed refusal following an official review process).

The legal landscape in the United States is not uniform. Montana is the only state that does not allow involuntarily hospitalized individuals to waive their right to legal representation. Although this ensures that every individual receives legal counsel, it may also unreasonably restrict personal autonomy. By contrast, all other states permit waiving representation. Although some states impose strict requirements for waiver, similar to the conditions required for waiving legal representation in criminal proceedings. Such a policy may provide a possible framework for balancing individual autonomy with the critical need for legal representation.

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[213] *See In re S.M.*, 403 P.3d at 330–31.

[214] *Id.*

In other states, the situation is closer to the Opt-In model, but with a key difference: in the U.S., the competence standard for waiving legal representation in civil commitment cases is based on awareness of the hospitalization process and a basic understanding of its implications. This is unlike Israeli law, which requires consent but does not specify its nature or the competence threshold required. The United States standard is lower than the one required to waive legal representation in criminal cases.

The discussion presented thus far is insufficient by itself to determine which model should be preferred—the Opt-In model, the Mandatory Representation model, or the Opt-Out model. This question becomes particularly complex due to the unique considerations involved in involuntary hospitalization. While the purpose of involuntary hospitalization is to provide treatment and improve the individual's condition, it also represents a significant deprivation of liberty, necessitating careful scrutiny.

In the absence of comprehensive research evaluating the effectiveness of legal representation for involuntarily hospitalized individuals, both represented and unrepresented, the following empirical study assesses the substantive and procedural consequences of representation. Although there is broad agreement on the importance of legal representation, whether legal representation might harm the well-being of individuals with mental disorders and whether it truly guarantees a fair process remains unknown. We expected our findings to offer preliminary insights on how to shape a model that optimally safeguards both legal protection and personal well-being for those subject to involuntary hospitalization.

Previous studies, by the authors of this paper, which form the foundation of this research, demonstrated that legal representation does not compromise the quality of care or lead to higher rates of repeated hospitalizations. These findings reinforced the conclusion that legal representation contributes to protecting the rights of involuntarily hospitalized individuals and enhancing their autonomy. Building on these findings, the following study examined whether and how legal representation contributed to procedural fairness in psychiatric board hearings and the extent to which it influenced their outcomes.

If it is empirically demonstrated that legal representation (a) does not negatively affect treatment quality and (b) enhances procedural fairness for involuntarily hospitalized individuals, then serious consideration must be given to whether the current Israeli legal model is indeed the most effective. Alternatively, it may be necessary to explore other models—such as those adopted in various U.S. states—that better realize this right while minimizing potential infringement on personal autonomy. While the legal landscape in the United States is diverse, with some states also employing Opt-In models, many others have adopted Opt-Out or Mandatory Representation

frameworks that ensure broader access to legal assistance. These approaches offer valuable lessons for Israel, highlighting the potential of presumptive or automatic representation to better safeguard individual rights. In light of these comparative insights, Israel should consider shifting to an Opt-Out model or, at a minimum, establishing clearer procedures to ensure that any waiver of representation is informed and subject to judicial oversight.

V. THE EMPIRICAL STUDY

A. Research Topic and Research Questions

Building on the findings of our previous studies, this research examined whether legal representation contributed to protecting the due process rights of individuals subject to involuntary hospitalization. Importantly, the study's findings align with the key conclusion from prior research that legal representation does not jeopardize treatment effectiveness. Taking this together supports our recommendation to reform the current legal representation model in Israel.

B. Research Methodology

This was a correlational study based on data analysis from three sources. The sources included: (1) the Ministry of Health database, (2) case file analysis, and (3) data from the Legal Aid Department of the Ministry of Justice. The latter consisted of data regarding the number of involuntarily hospitalized individuals who exercised their right to legal representation.

1. Analysis of the Ministry of Health Data

The first phase of the study involved examining the Ministry of Health database for the years 2000 and 2010. For each involuntarily hospitalized patient, we analyzed data spanning the six subsequent years from the first hospitalization in 2000 and 2010. This database contains data similar to a population census. It includes all individuals hospitalized for psychiatric reasons rather than a sample. A sample-based study examines only a portion of a population and requires statistical validation of its results. By contrast, because the Ministry of Health database is a comprehensive census that includes all individuals in the examined population, its results do not require statistical verification to support how it is representative of the population as a whole.

The database contains extensive information regarding psychiatric hospitalization in Israel. The recorded data include various aspects, such as the duration and type of hospitalization, whether voluntary or involuntary. Additionally, it provides details on the type of discharge from involuntary hospitalization: (1) duration of hospitalization; (2) type of hospitalization

(voluntary or involuntary); (3) type of discharge from involuntary hospitalization ((a) regular discharge by decision of the treating physician; (b) discharge by the DPB; and (c) discharge against medical advice where the psychiatrist recommended continued hospitalization but there was no legal basis to extend it; and other discharges that are not the focus of this study, such as transfer to another hospital, escape, or death)."Other discharges" were excluded from the study because of the inability to track these individuals over the six years following their release. In 2000, the number of "other discharges" was 249; in 2010, it was 237. After excluding these cases, the final sample included 2,875 individuals in 2000 and 3,195 in 2010.

This database did not contain information on legal representation provided to an individual; therefore, we compared two points in time, the year 2000 and the year 2010. The logic behind this choice was that in 2000, almost all patients lacked legal representation (only 5% had representation). Alternatively, in 2010, almost all patients had legal representation.

2. Case File Analysis

The Ministry of Health database revealed that certain key data were missing. Notably, the database did not specify whether an involuntarily hospitalized individual received legal representation during their hearings before the DPB. Because legal representation is the focus of the present study, we incorporated an additional research method: case file analysis.

Case files were requested of individuals hospitalized in 2000 and 2010 at three medical centers in the Jerusalem district. The request was approved by the Helsinki Committees responsible for ethical oversight of human research at the three centers. The case file analysis was conducted only in the Jerusalem district as this is the most populated district in Israel. The examined proceedings included nearly all the hearings held in this district, and since the same system is applied across all Israeli districts, it is reasonable to assume they are representative of hearings in other districts.

Because the case files were not available in digital format, significant effort was required to manually extract the information. Therefore, we relied on a sample of involuntarily hospitalized individuals from these medical centers: 139 case files from 2000 and 130 from 2010. The resulting dataset was sample-based; therefore, it required statistical analysis. The information was collected by one of the researchers who was charged with reviewing the files. To protect patient confidentiality, the collected data did not include any identifying information.

The case files contained psychiatric hospitalization history. Such documents may include: initial examination and hospitalization orders issued by the district psychiatrist; requests submitted by medical staff to the district psychiatrist or the DPB; nursing reports that the medical team completes

every few hours, documenting patient behavior in the ward; medical reports written by the treating psychiatrist; power of attorney forms and medical confidentiality waivers; and DPB hearing transcripts (51 hearings in 2000 and 53 hearings in 2010). In all other cases, extensions of involuntary hospitalization were made with the patient's consent.

For each case, we examined compliance with legal requirements. Legal requirement compliance included whether the medical staff properly referred the involuntarily hospitalized individual to a DPB hearing as required by law, and the conduct of DPB hearings. For the conduct of the hearing, the study focused on the length of the hearing transcript, the extent of witness cross-examinations, whether the DPB inquired about the individual's preferences, whether the DPB provided a reasoned decision, as required for quasi-judicial proceedings, and whether the chairperson (a legal professional) dissented from the opinion of the other panel members (psychiatrists).

C. Research Findings

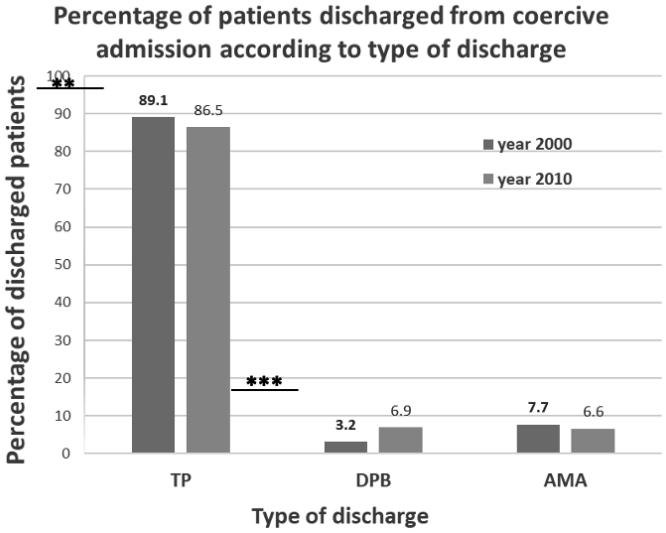
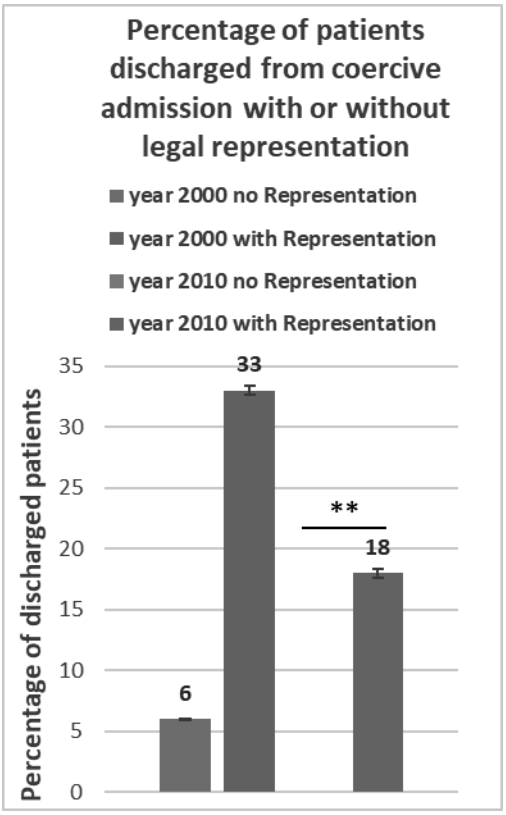


Figure 1a: For each pair of columns compared in the figures, a line appears above the relevant columns, and significance levels are indicated as follows: *P-value <0.05, ** P-value <0.01, *** P-value <0.001*. The sample sizes of the Ministry of Health database analysis were N=2,875 in 2000 and N=3,195 in 2010.

Figure 1a shows the percentage of individuals released by the DPB, TP, or AMA in the years 2000 and 2010. The percentage of discharged patients doubled from 3.2% in 2000 to 6.9% in 2010, representing a statistically significant increase. According to the available data, in 2010, 93.7% of



involuntarily hospitalized individuals received legal representation, compared to 5% in 2000. Therefore, the figure demonstrates a clear and significant increase in discharges by the DPB when almost all patients were legally represented, contrary to when they were not legally represented. We also examined this issue in the case file analysis, which reinforced the finding that there was indeed an increase in the percentage of represented individuals released by the DPB:

Figure 1b: For each pair of columns compared in the figures, a line appears above the relevant columns, and significance levels are indicated as follows: *P-value <0.05, ** P-value <0.01, *** P-value <0.001*. The standard deviation for each column is displayed. The sample sizes of the case file analysis were N=51 in 2000 and N=53 in 2010. No unrepresented cases were recorded in 2010 (value = 0).

The research hypothesis predicted an increase in DPB discharges among legally represented patients. This hypothesis was based on the assumption that the presence of an attorney would shift and potentially tilt the focus of DPB hearings away from purely medical considerations, such as whether the individuals have a mental disorder, toward legal considerations, such as proving the individuals' dangerousness and the causal link between their mental illness and potential harm. Shifting the hearing's focus to legal standards, including the burden of proof, was expected to lead to a higher percentage of releases by the DPB. Figure 1a shows that the research hypothesis was confirmed. This can also be seen in Figure 1b, which shows the percentage of patients released from coercive admission in 2000 versus 2010. Here, we could also directly compare legally represented patients with those who did not receive legal representation, since the figure is based on

case file analysis, which includes this data. Similarly, using this method, we view a significant increase in discharges in legally represented patients.

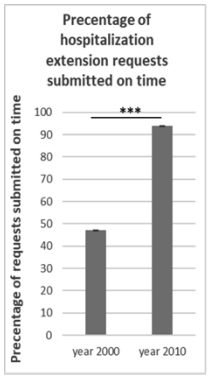


Fig. 2A

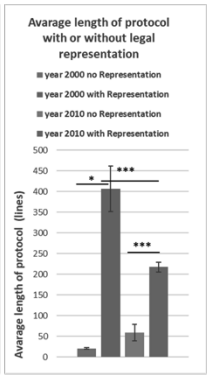


Fig. 2B

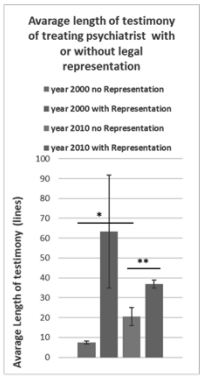


Fig. 2C

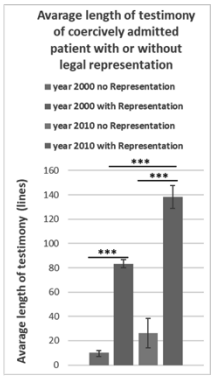


Fig. 2D

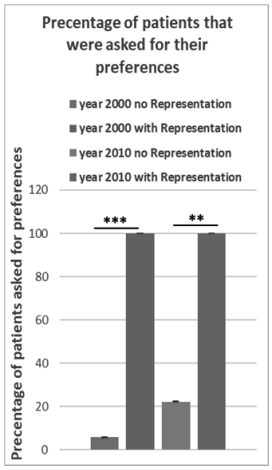


Fig. 2E

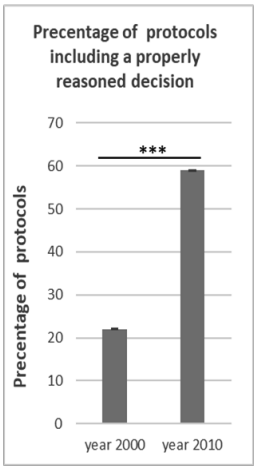


Fig. 2F

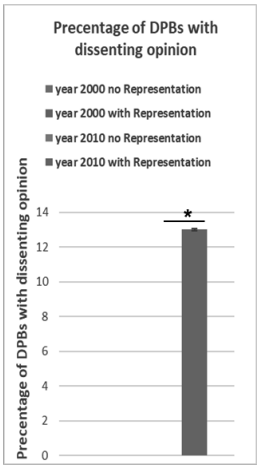


Fig. 2G

Figures 2A-2G: For each pair of columns compared in the figures, a line appears above the relevant columns, and significance levels are indicated as follows: *P-value <0.05, ** P-value <0.01, *** P-value <0.001*. The standard deviation for each column is displayed. The sample sizes of the case file analysis were N=51 in 2000 and N=53 in 2010.

Figures 2A-2G examine the impact of legal representation on various aspects of protecting the rights of involuntarily hospitalized individuals in DPB hearings. The rights examined included the hospital staff's adherence to legal timelines for submitting requests for hospitalization extensions, the procedural conduct of the DPB, and the requirement to provide a reasoned decision. The length of the patient's testimony, the psychiatrist's testimony,

and the overall length of the protocol were also evaluated as measures of the extent of inquiry the DPB undertakes before deciding whether to continue coercive admission.

Figure 2A illustrates the hospital staff's adherence to the legal requirement of submitting timely hospitalization extension requests. It shows a statistically significant increase in staff compliance with legal deadlines, increasing from 50% in 2000 to nearly 100% in 2010. The research hypothesis was partially confirmed, as we did not expect such a low compliance rate in 2000 with legally mandated deadlines.

Figure 2B shows the adherence of the DPBs to recording hearing transcripts, given their importance in reflecting the proceedings and enabling judicial review when necessary. Our hypothesis predicted no significant change in transcript length between 2000 and 2010. The analysis was conducted by counting the number of lines in the transcripts, based on the assumption that a higher line count more accurately reflects the content of the hearing. A significant increase was found between the two periods, from an average number of around 30 lines in 2000 to approximately 210 lines in 2010. The research hypothesis was only partially confirmed, as we did not expect a sevenfold increase.

In 2010, we found a significant difference between represented and unrepresented individuals. Although transcripts of hearings involving represented individuals totaled approximately 210 lines, those involving unrepresented individuals totaled only about 70 lines. Therefore, the research hypothesis was not fully supported. Still, the situation of unrepresented individuals in 2010 was better than in 2000 (30 lines in 2000 vs. 70 lines in 2010).

Figure 2C describes the length of the psychiatrist's testimony at DPB hearings. The hypothesis predicted that in the absence of legal representation, the psychiatrist's role in providing information to the DPB would remain the same or even increase because of concerns expressed by psychiatrists about the "legalization" of the commitment process. The analysis, however, found that the psychiatrist's testimony in 2010 was significantly longer than in 2000; therefore, the research hypothesis was not confirmed.

Figure 2D shows the length of the hospitalized individuals' testimony before the DPB. The hypothesis predicted no significant change between 2000 and 2010, but the study found a statistically significant increase in the length of the testimony. Therefore, the research hypothesis was not confirmed.

In 2010, we found a significant difference between represented and unrepresented individuals. The average number of transcript lines per represented individual was approximately 120, whereas for an unrepresented

individual, it was around 30. Although the research hypothesis was not confirmed, similar to the data in Figure 2B, the length of testimony for unrepresented individuals increased in 2010 compared with 2000.

Figure 2E indicates whether the DPB inquired about the individuals' preferences. This question appears as a standard item in the DPB hearing transcript template; therefore, we hypothesized that there would be no significant change between the two study periods. The findings show that in 100% of cases where the hospitalized individual was represented, both in 2000 and 2010, the DPB explicitly inquired about their preference. By contrast, when the individual was unrepresented, the percentage of cases where the DPB inquired about their preference was at most 20%. Inquiring about individuals' preferences is a key indicator of personal autonomy, and the findings suggest that legal representation reinforces the DPB's commitment to considering individuals' wishes and protecting their autonomy.

Figure 2F shows the percentage of DPB hearing transcripts that included a properly reasoned decision. The research hypothesis predicted a statistically significant increase between 2000 and 2010. This hypothesis was confirmed, although even in 2010, only 60% of DPB transcripts clearly conveyed the Board's decision-making process. Thus, despite legal representation, the DPB still failed to provide adequate reasoning in a substantial number of cases.

Figure 2G illustrates the number of cases in which the DPB chairperson issued a dissenting opinion. In 2000, whether the individual was represented or unrepresented, no cases were found in which the chairperson dissented. But in 2010, dissenting opinions were recorded in six cases—approximately 10% of the hearings. Based on an analysis of DPB transcripts, dissenting opinions should have been issued more frequently. In legal proceedings, and particularly in DPB hearings, dissenting opinions are an important safeguard of procedural fairness. They provide a platform for alternative perspectives and deepen decision-making in commitment cases, which involve complex interactions between medical, legal, and ethical considerations.

Publishing dissenting opinions enhances public confidence in the objectivity and transparency of DPB decisions. Dissenting opinions also serve as a basis for future judicial review and appeals, helping prevent rigid decision-making and promoting accountability and fairness. Therefore, ensuring that dissenting opinions are carefully considered in appropriate cases is critical for procedural justice and for safeguarding the rights of involuntarily hospitalized individuals.

D. Study Limitations

The ideal method for isolating the effect of legal representation is a controlled experiment in which two groups of involuntarily hospitalized individuals are observed at the same time—one with legal representation, the other without. Given Israel's current legal framework, such an experiment could not be conducted. As a result, the present study relies on observational data and employs alternative strategies to approximate the causal effect of legal representation. This study uses two methods: the Ministry of Health database and the Case File Analysis. The Case File Analysis's primary limitation is that the sample size was relatively small, and all the files were from hospitals in the Jerusalem district. Another limitation is that the case files were continually updated by hospital staff. There is a possibility that certain documents were not filed or may have been lost. Similarly, the Ministry of Health database was updated based on reports submitted by psychiatric hospitals to the Ministry of Health. This raises the possibility of reporting inaccuracies or discrepancies between records and actual events.

1. Comparison of Individuals in Two Time Periods

Because a controlled experiment was not possible, the study relied on data from the Ministry of Health database. Thus, we could compare a time when almost all patients were legally represented (2010) with a time when almost all patients were not represented (2000). However, in the ten years between these time points, multiple changes occurred. One such change was the implementation of state-funded legal representation at DPB hearings. This and other changes may have influenced the rates of repeated hospitalization and DPB decisions, including the development of new psychiatric medications, revisions to hospitalization admission procedures, changes in mental health policy, and fluctuations in the availability of psychiatric hospital beds.

2. Analysis of Ministry of Health Data and Case File Analysis

As mentioned, the database does not specify which patients had legal representation, how many DPB hearings each individual underwent, or the outcomes of those hearings. In addition to comparing two time points using the database, we therefore conducted the Case File Analysis. Using the Case File Analysis, we could access all the information in the file, including data on legal representation and the hearing itself. We believe the data is reliable and accurate because we combined two techniques. The Ministry of Health database provided a broad perspective and was based on thousands of patients. However, this database did not contain some data we needed—such as legal representation. For this purpose, we used the Case File Analysis, which was smaller in scale but rich in information about each individual admitted. We believe that the research findings contribute meaningfully to

the discussion on the optimal legal representation model for involuntarily hospitalized individuals.

VI. DISCUSSION

A. Introduction

The empirical study's findings attest to the positive effect of providing the right to legal representation in involuntary hospitalization proceedings. Specifically, we found an increase in the percentage of involuntarily hospitalized individuals who were released by the DPB. These results support the view that legal representation contributes to safeguarding individual rights during psychiatric commitment procedures.

Moreover, the case file analysis shows a significant improvement in safeguarding the due process rights of involuntarily hospitalized individuals, particularly for those with legal representation, compared with those without. This improvement was evident in both the comparison between 2000 and 2010 and the comparison between represented and unrepresented individuals in 2010. Based on these findings, it is reasonable to attribute this improvement in patients' rights to the legal representation they received.

In light of these findings, the question arises: What is the most effective legal representation model for involuntarily hospitalized individuals to maximize their access to adequate representation? The models under consideration are the current model in Israel and most U.S. states (Opt-In), which requires explicit consent for legal representation, and the Opt-Out model, where representation is presumed unless the individual explicitly waives the right to it.

At the same time, we do not argue that a model that mandates legal representation without an option to waive has no advantages, particularly for individuals with mental disorders. The Mandatory Representation Model ensures that all involuntarily hospitalized individuals receive legal representation. This model guarantees patient interests are adequately represented before professional bodies, such as psychiatric committees in Israel or courts in the U.S. Such a model could be more beneficial in the U.S. legal system, where courts oversee involuntary hospitalizations. Such a model would be less beneficial in Israel because decisions are based primarily on medical considerations, given the composition of the Board, which includes two psychiatrists.

We believe an Opt-Out model strikes the ideal balance between the three models because legal representation is automatically provided and can be waived after it has been granted, rather than requiring explicit consent beforehand. We argue that such a model preserves autonomy to a greater extent than the Mandatory Representation model because it mandates legal

representation without prior decision-making ability but allows individuals to waive representation after it has been provided, subject to a professional assessment of their autonomy.

The following discussion focuses on three key aspects of our proposal. Specifically: (1) a bioethical analysis of the tension between autonomy and paternalism, with an emphasis on the right to legal representation for individuals with mental disorders; (2) a legal analysis of the existing framework in Israel and the U.S.; and (3) proposed legal and procedural reforms. The analysis aims to reach well-founded conclusions regarding the appropriate model for legal representation in involuntary hospitalization proceedings, balancing the protection of rights with ensuring the health and well-being of the patients.

B. A Bioethical Perspective

The two legal representation models discussed, Opt-In and Opt-Out, are underpinned by the competing considerations of paternalism and autonomy. Both models seek to safeguard the right of individuals with mental disorders to legal representation but differ in the mechanisms used to implement this right and the balance they strike between paternalistic intervention and individual autonomy. In choosing the appropriate legal model, it is important to evaluate the potential infringement on personal autonomy in each.

The Opt-In model respects the autonomy of involuntarily hospitalized individuals, allowing them to independently decide whether to exercise their right to legal representation. This model enables individuals to exercise personal judgment in deciding whether to obtain legal representation or waive it. Autonomy is particularly important for individuals experiencing loss of control, as it encourages cooperation with the treatment system. At the same time, there is a risk that individuals may waive representation because of a lack of competence or understanding of the legal consequences. In cases of severe mental health conditions, like schizophrenia or major depressive disorder, such a decision may not reflect the individual's best interests. Therefore, professional oversight is required to ensure that waiver decisions are made competently and not due to impaired judgment.

Conversely, the Opt-Out model grants automatic eligibility for legal representation, eliminating the need for the individual to make an active decision. This ensures that the rights of individuals with mental disorders are protected from the outset, preventing situations where individuals waive representation because of a lack of competence or understanding. This model ensures a balanced and fair legal process but may be perceived as paternalistic because it mandates representation by default and requires the individual to actively refuse to opt out.

Feinberg's distinction between soft and hard paternalism is relevant here. According to Feinberg, soft paternalism is not considered an undue restriction on individual freedom, as its goal is to protect individuals when their decisions are not based on full understanding or informed judgment. Soft paternalism is based on the hypothetical consent principle—the assumption that, if individuals fully understood the consequences of their decisions, they would agree to protective interventions. The Opt-Out model aligns with this principle: it does not revoke personal choice but ensures that any waiver of legal representation is made with full understanding and competence, subject to legal oversight.

The presumption of consent in the Opt-Out model ensures that individual autonomy is not compromised, particularly when an option to waive representation is provided under legal supervision. Furthermore, even if the Opt-Out model is perceived as paternalistic, it constitutes soft paternalism, which Feinberg justifies in cases where individuals may lack competence to make informed decisions. Therefore, Opt-Out provides an optimal balance between safeguarding legal rights and respecting individual autonomy.

C. Legal Analysis

In Israel, the Mental Health Act regulates the rights of involuntarily hospitalized individuals with mental health conditions, including the right to legal representation before psychiatric boards. The realization of this right, however, is contingent upon the mentally ill individual expressing a desire for representation. When the patient's wishes cannot be ascertained, the law obliges the physician to inform the patient's guardians of their right to legal representation. The law does not explicitly address cases in which the hospitalized individual refuses representation, but the Mental Health Regulations, enacted after the Mental Health Act, address this possibility. The regulations stipulate that individuals with mental health conditions must sign a form refusing legal representation, and if they refuse to sign, the physician is required to document this on the form. The regulations do not mandate the physician to assess whether the individual is competent to refuse representation, leaving the discretion to examine this issue to the psychiatric board, which in practice rarely conducts such assessments.

A similar legal framework exists in some U.S. states, where the appointment of legal counsel for involuntarily hospitalized individuals follows an Opt-In model, requiring individuals to actively request representation. The courts are required to appoint an attorney only if the individual does not have one, and do not mandate proactive appointment unless requested. This parallels the Israeli framework, where legal representation is available in principle but requires the individual's expressed consent. Furthermore, as in Israel, these U.S. jurisdictions generally do not

impose an obligation on medical professionals to assess an individual's competence to refuse representation, leaving such determinations to judicial or administrative discretion, which may not always be exercised in practice.[215]

Recognition of a hospitalized individual's right to waive legal representation aims to empower individuals with mental health conditions and ensure their equal standing with others in making legal decisions. Similarly to criminal proceedings, where the legislation assumes consent to representation because of concerns over potential violations of individual rights, involuntary hospitalization procedures also pose a significant risk to fundamental rights, particularly because of the deprivation of liberty inherent in such processes. In cases of involuntary hospitalization, where the deprivation of liberty is substantial and often includes forced medication and restrictive measures such as restraints, there may be an even stronger justification for automatic legal representation. As in criminal proceedings, the potential infringement on fundamental rights necessitates enhanced legal protection, justifying the provision of representation even when individuals with mental health conditions have not explicitly expressed a desire for it. Such representation ensures the preservation of due process and the protection of individual rights, even when the patient's competence or ability to express their will may be compromised by their mental state.

The prevailing legal perspective favors individual autonomy over paternalistic principles, even in the case of individuals with mental health conditions. Our findings, however, indicate that legal representation does not harm involuntarily hospitalized individuals but rather benefits them. Case file analysis reveals distinct positive effects of legal representation compared to cases without representation, with significant differences observed in the conduct of psychiatric boards over the years of the study.

Although these findings are significant, it is possible to argue that the change in Board conduct does not necessarily stem from the work of attorneys. Rather, from a broader legal trend following the establishment of the right to representation. In this sense, mere recognition of the right to representation may have shifted the legal focus of Board proceedings, influencing their conduct even when representation was not actually provided.

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[215] *See, e.g.*, N.Y. MENTAL HYG. LAW § 9.31 (McKinney 2023); TEX. HEALTH & SAFETY CODE ANN. § 574.105 (West 2023); FLA. STAT. ANN. § 394.467 (West 2023); OHIO REV. CODE ANN. § 5122.15 (West 2023); 405 Ill. Comp. Stat. 5/3-805 (West 2023).); MISS. CODE ANN. § 41-21-67 (West 2023). Additionally, in some states, individuals subject to involuntary hospitalization retain the right to legal counsel, but the realization of this right depends on their explicit request. *See, e.g.*, N.C. GEN. STAT. § 122C-268 (2023); IND. CODE ANN. § 16-39-1-8 (West 2023).

Our research findings, however, indicate a different reality. When comparing cases involving represented individuals with those involving unrepresented individuals in 2010, we found that in the absence of legal representation, the DPB operated in a manner similar to its conduct in the years preceding the implementation of the right to representation. For example, when representation was absent, the Board did not seek the hospitalized individual's opinion, whereas in 100% of cases where representation was provided, the Board did inquire about the individual's stance. This trend was consistently reflected in the other parameters examined.

Our findings demonstrate that legal representation for individuals with mental health conditions significantly improves the conduct of psychiatric boards, ensuring better protection of hospitalized individuals' rights. When individuals were represented, their rights were consistently upheld, and the Board placed greater emphasis on hearing their opinions. This situation represents a relative improvement, especially considering the legal reality before this change in the law, where no right to representation existed. Therefore, efforts should be made to extend the Opt-Out model, which provides automatic eligibility for legal representation, to as many hospitalized individuals as possible. Adopting this model is expected to increase the exercise of this right and ensure more equitable treatment of all individuals with mental health conditions.

D. Normative Recommendations

To align the handling of the involuntary hospitalization of mentally ill patients with the normative conclusions presented here, we propose several changes to current regulations. Specifically, these aim to ensure automatic legal representation (Opt-Out model) for involuntarily hospitalized individuals while maintaining a balance between autonomy and adequate legal protection. In particular, the proposed changes focus on enhancing the protection of individuals' rights and regulating procedures to ensure their competence when they waive representation.

Automatic legal representation (Opt-Out model): The law should ensure that all involuntarily hospitalized individuals receive automatic legal representation, regardless of whether they explicitly requested it. This will guarantee that individuals in a deteriorated mental state, who may not understand the implications of waiving representation, receive legal protection. The presumption should be that individuals wish to be represented unless they explicitly request to waive this right after receiving a full explanation of the legal significance and consequences of such a decision.

Regulating the waiver of representation: To prevent automatic or hasty waivers of representation, the law must clearly regulate the waiver process. It should

be stipulated that a waiver can occur only following an assessment of the individual's competence by a professional (such as a psychiatrist or attorney) who evaluates their ability to understand the consequences of waiving representation. If the individual is deemed incompetent to make such a decision, legal representation must continue to be provided. Furthermore, the decision to waive representation should be documented in writing only after individuals receive a detailed explanation of their rights.

Judicial review of representation refusals: The law should impose an obligation on the psychiatric board to examine the competence of individuals who refuse representation and to subject these decisions to judicial review. The review should include an option for reassessment in cases where there is concern about the infringement of individuals' rights. The board should ensure that the waiver of representation is made competently and with full understanding.

Implementing oversight and training mechanisms: The law should incorporate oversight and training mechanisms essential to ensure that medical and legal personnel are aware of the importance of individuals' rights. These mechanisms must be institutionalized and continuously monitored. Moreover**,** support systems should be developed to guarantee the actual exercise of representation rights, including education for medical staff, attorneys, and individuals with mental health conditions about their rights and the representation process.

VII. CONCLUSION

The findings presented in this Article lead us to conclude that the Opt-Out model is the preferred model for involuntary hospitalization proceedings. This model, which provides automatic legal representation for all individuals with mental health conditions, ensures due process and eliminates reliance on individual decisions to seek representation. Legal representation has been shown to improve the conduct of psychiatric boards, primarily by ensuring that boards consider the hospitalized individual's views and operate with transparency. More importantly, the findings indicate that representation does not hinder the therapeutic process but rather supports it, as it enhances the hospitalized individual's sense of security and leads to more well-founded decisions that integrate both therapeutic and legal considerations.

Moreover, the Opt-Out model does not infringe upon the autonomy of hospitalized individuals; rather, it strengthens it. The presumption of consent, which underlies this model, combined with the option to waive representation under supervision, ensures that individual autonomy is preserved even in sensitive situations. Even if this model is perceived as paternalistic, it constitutes a form of soft paternalism, which is justifiable in

view of the literature, particularly when dealing with vulnerable populations and situations where fundamental rights are at risk. Therefore, the Opt-Out model is the superior choice among existing models, as it balances effective protection of hospitalized individuals' rights, ensures due process, and respects the patients' autonomy while creating a more equitable and efficient legal framework.