



UNC
SCHOOL OF LAW

NORTH CAROLINA LAW REVIEW

Volume 60 | Number 5

Article 3

6-1-1982

Involuntary Civil Commitment in North Carolina: The Result of the 1979 Statutory Changes

Robert D. Miller

Paul B. Fiddleman

Follow this and additional works at: <http://scholarship.law.unc.edu/nclr>



Part of the [Law Commons](#)

Recommended Citation

Robert D. Miller & Paul B. Fiddleman, *Involuntary Civil Commitment in North Carolina: The Result of the 1979 Statutory Changes*, 60 N.C. L. REV. 985 (1982).

Available at: <http://scholarship.law.unc.edu/nclr/vol60/iss5/3>

This Article is brought to you for free and open access by Carolina Law Scholarship Repository. It has been accepted for inclusion in North Carolina Law Review by an authorized administrator of Carolina Law Scholarship Repository. For more information, please contact law_repository@unc.edu.

INVOLUNTARY CIVIL COMMITMENT IN NORTH CAROLINA: THE RESULT OF THE 1979 STATUTORY CHANGES

ROBERT D. MILLER†
PAUL B. FIDDLEMAN‡

In the past several years, the statutory procedures for involuntary commitment have undergone broad revision nationwide. The basic thrust of this change has been to transform commitment proceedings from a medical process into a legal process that focuses on the due process rights of the involuntary commitment respondents. This change manifested itself in North Carolina in the 1979 amendments to the commitment statutes. Dr. Miller, a member of the task force that recommended changes in the commitment statute to the General Assembly, and Dr. Fiddleman chronicle the changes that have occurred on a national scale. They then present a detailed description of the current North Carolina commitment statutes and analyze the impact of these changes on the commitment process. The authors bring an experienced medical viewpoint to the discussion of the proper roles of psychiatrists and attorneys in the commitment process, and they conclude that the statutory changes in response to increased due process concerns are perhaps not in the best interest of commitment respondents.

I. INTRODUCTION

The procedures for involuntary civil commitment of the mentally ill have undergone a revolution in the past fifteen years, from a clinical procedure essentially under complete control of the medical profession to a much more formalized legal process that recognizes that patients' due process rights must be observed if the state is to restrict their liberties. This Article will survey these changes on a national scale and will present a description of the current status in North Carolina, where the statutes have been changed in some instances to conform to court decisions affecting commitment. Studies of the effects of the most recent statutory changes, which went into operation in 1979,

† Director of Residency Training and Clinical Research, John Umstead Hospital, Butner, North Carolina; Clinical Associate Professor of Psychiatry, Duke University Medical Center, Durham, North Carolina. B.S. cum laude 1964, Davidson College; Ph.D. 1972, M.D. 1973, Duke University.

‡ Research Psychologist, John Umstead Hospital, Butner, North Carolina; Associate Professor of Psychology, University of North Carolina at Chapel Hill. A.B. 1955, CUNY/Brooklyn; M.A. 1957, Ph.D. 1961, University of North Carolina at Chapel Hill.

The authors wish to express appreciation to Ms. Shirley Carlisle, Special Counsel at John Umstead Hospital; to Wilson Hayman, Associate Attorney General at John Umstead Hospital; and especially to their legal secretaries, Ms. Deborah Daniel and Ms. Jane Brame, for their cooperation and for their time in excerpting material from their legal files for this study.

will be presented in detail, and an analysis of the impact of these statutes on the practice of involuntary treatment will be undertaken.

Because of the recent appearance in this Review of an excellent analysis of the procedures for the "voluntary" admission of minors by their legal guardians,¹ this area of commitment practice will not be treated. North Carolina law permits formal involuntary commitment of persons without regard to age;² but because of rigorous statutory protections, the records of involuntarily committed minors are not available to the public,³ and therefore this Article contains only data from commitment proceedings involving persons eighteen years of age and older. Minors represent only a small percentage of involuntarily committed persons in North Carolina,⁴ and there is no reason to assume any significant differences in this population from the one studied, as the commitment procedures for juveniles are identical to those for adults.⁵

II. HISTORICAL BACKGROUND

One result of the civil rights movement of the 1960s was a growing interest by attorneys and courts in the process of involuntary civil commitment of the mentally ill. Prior to this period, commitment, although authorized by statute in every state, had been essentially a clinical procedure requiring only certification by one or more physicians with only minimal or no judicial review available.⁶ A series of articles describing existing conditions and calling for reforms⁷ in the process raised the interest of the legal profession. A major

1. Silverstein, *Civil Commitment of Minors: Due and Undue Process*, 58 N.C.L. Rev. 1133, 1159 (1980).

2. N.C. Gen. Stat. § 122-58.3 (1981). The language of the statute refers to "mentally ill or inebriate persons" with no mention of age limits. See Opinion of the Attorney General to Mr. R. G. Frye, Jr., 43 N.C.A.G. 161 (1973).

3. N.C. Gen. Stat. § 122-56.8 (1981). Section 122-56.9 provides for access to these records pursuant to an order from a district court judge after written application. We deemed a court order unnecessary due to hospital attorneys' cooperation and because of the relatively small number of commitments for minors as compared with adults. See note 4 *infra*.

4. The majority of patients under the age of eighteen at John Umstead Hospital (an average of 85%) are admitted under the provisions of N.C. Gen. Stat. § 122-56.7 (1981).

5. *Id.* §§ 122-58.3 to -58.21 (1981). No mention of age limits is made in any of these statutes governing involuntary commitment, implying that the statutes apply to all ages. See note 2 *supra*.

6. For an historical survey of the treatment of the mentally ill in this country, see A. Deutsch, *The Mentally Ill in America* (2d ed. 1949). More detailed descriptions of conditions in the 1950s and 1960s, before and after the reform movements began to have an effect, can be found in Andalman & Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal*, 45 *Miss. L.J.* 43 (1974); Cohen, *The Function of the Attorney in the Commitment of the Mentally Ill*, 44 *Tex. L. Rev.* 424 (1966); Curran, *Hospitalization of the Mentally Ill*, 31 N.C.L. Rev. 274, 285 (1953); Johnson, *Due Process in Involuntary Civil Commitment and Incompetency Adjudication Proceedings: Where Does Colorado Stand?*, 46 *Denver L.J.* 516 (1969); Miller & Schwarz, *County Lunacy Commission Hearings: Some Observations of Commitments to a State Mental Hospital*, 14 *Soc. Probs.* 26 (1966); Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 *Mich. L. Rev.* 945 (1959); Wexler & Scoville, *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 *Ariz. L. Rev.* 1 (1971); Projects: *Civil Commitment of the Mentally Ill*, 14 *U.C.L.A. L. Rev.* 822 (1967).

7. Andalman & Chambers, *supra* note 6, at 75; Bassiouni, *The Right of the Mentally Ill to Cure and Treatment: Medical Due Process*, 15 *DePaul L. Rev.* 291, 308 (1966); Brunetti, *The Right to Counsel, Waiver Thereof, and Effective Assistance of Counsel in Civil Commitment Proceedings*, 29 *Sw. L.J.* 709 (1975); Cohen, *supra* note 6, at 450; Curran, *supra* note 6, at 297;

thrust of these articles was the need to provide civilly committed persons with due process protections, including adequate judicial hearings on continuation of involuntary hospitalization and treatment, and the presence of effective adversary counsel at all stages of the process to prepare defenses and ensure the observation of other due process rights.⁸

These authors believed that the then current practices were heavily weighted against the allegedly mentally disordered patients presented before the court in involuntary commitment proceedings (hereinafter referred to as respondents) for the following reasons: (1) Respondents, often indigent and ignorant of their rights, were denied competent adversarial counsel with sufficient time to prepare effective defenses.⁹ (2) Judges, hearing officers and most of the attorneys (if any were involved) gave undue weight to the testimony of expert clinical witnesses, usually psychiatrists, from the hospitals where the respondents were committed. Physicians routinely were allowed to make conclusory statements without presenting the data from which they made their conclusions.¹⁰ (3) The criteria for commitment were phrased much too loosely

Johnson, *supra* note 6, at 561; Kutner, *The Illusion of Due Process in Commitment Hearings*, 57 *Nw. U.L. Rev.* 383, 398 (1962); Projects, *supra* note 6, at 866.

8. Andalman & Chambers, *supra* note 6, at 75; Brunetti, *supra* note 7, at 709; Cohen, *supra* note 6, at 450; Johnson, *supra* note 6, at 565.

9. Andalman & Chambers, *supra* note 6, at 72; Brunetti, *supra* note 7, at 66; Caldwell, *The Expanding Role of the Lawyer and the Court in Securing Psychiatric Treatment for Patients Confined Pursuant to Civil Commitment Procedures*, 6 *Houston L. Rev.* 519 (1969); Cohen, *supra* note 6, at 444; Miller & Schwarz, *supra* note 6, at 522; Ross, *supra* note 6, at 971. Several courts have found a denial of effective assistance of counsel. See, e.g., *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972); *Hawks v. Lazaro*, 157 W. Va. 417, 202 S.E.2d 109 (1973); *State ex rel. Memmel v. Mundy*, 75 Wis. 2d 276, 249 N.W.2d 573 (1977). The Wisconsin decisions are discussed in Note, *Recent Decisions—Mental Health*, 61 *Marq. L. Rev.* 187 (1977); *Lessard v. Schmidt* is discussed in detail in Zander, *Civil Commitment in Wisconsin: The Impact of Lessard v. Schmidt*, 1976 *Wis. L. Rev.* 503.

10. Andalman & Chambers, *supra* note 6, at 57; Bassiouni, *supra* note 7, at 295; Cohen, *supra* note 6, at 436; Kutner, *supra* note 7, at 385; Maisel, *Decision-Making in a Commitment Court*, 33 *Psychiatry* 352 (1970); Ross, *supra* note 6, at 961; Steadman, *The Psychiatrist as Conservative Agent of Social Change*, 20 *Soc. Probs.* 263 (1972). Although it is true that many psychiatrists have been too comfortable with the authority tacitly or explicitly given to them by the courts and legislatures, it is equally true that the authority has always rested with the legal profession and was delegated knowingly. Many judges have led the trend towards redefining criminal behavior as mental illness, both to rehabilitate the offender and to reduce crowding in the penal system. See S. Halleck, *Politics of Therapy 178-86* (1963); T. Szasz, *Law, Liberty, and Psychiatry* (1963). These authors also point out that judges (and society in general) prefer to excuse some lawbreakers to expiate some of the guilt engendered by punishing the rest.

In North Carolina, judges have taken similarly paternalistic positions, most notably in the pending (at the time of this writing) case of *Willie M. v. Hunt*, No. CC 79-294, related decisions, 657 F.2d 55 (4th Cir. 1981) (composition of class); 90 F.R.D. 601 (W.D.N.C. 1981) (attorney's fees). The suit is a class action filed on behalf of plaintiff and all other similarly situated violent adolescents for whom no treatment programs existed in North Carolina at the time of the initiation of the suit. It was filed as a result of a long campaign by a juvenile court judge to force the mental health system to provide treatment for the named class—a group that clinicians feel suffers from no currently treatable mental illnesses. The suit has already resulted in the creation of one "re-education" facility for such adolescents, located at John Umstead Hospital.

Nicholas Kittrie defines the process he calls "divestment" as a relinquishing of the jurisdiction of the criminal law system over many of its traditional subjects and jurisdictions. N. Kittrie, *The Right to Be Different: Deviance and Enforced Therapy* 4 (1971). He points out that in some jurisdictions the mentally ill, juveniles, alcoholics, drug addicts and sociopaths all have been held immune from criminal responsibility. If taken to an extreme, these exceptions could apply to nearly half of the United States population. Ennis and Litwack state that "legislatures and courts,

in clinical terms such as "gravely disabled" and "in need of care and treatment" rather than in objective terms amenable to decisionmaking by lay persons in courts.¹¹ (4) The majority of civil commitments were being carried out ostensibly under the *parens patriae* power of the state but without sufficient evidence of compelling state interest to assume that power for legally competent adults.¹² (5) Psychiatrists, willingly or unwittingly, were colluding with families who were unwilling to care for mentally disordered relatives,¹³ com-

in an attempt to shift responsibility for making the determination of who shall remain free and who shall be confined, have turned to psychiatry, seeking easy answers where there are none." Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Calif. L. Rev. 693, 752 (1974).

For a variety of reasons, psychiatrists have expanded their definitions of mental illness to fill the vacuum. The new Diagnostic and Statistical Manual of Mental Disorders (3d ed. 1980) [hereinafter cited as DSM III], the official publication of the American Psychiatric Association, lists a wide variety of conditions now considered to be "mental disorders," including tobacco dependence (§ 305.1) and caffeine intoxication (§ 305.90), plus a large number of "unspecified disorders" that allow psychiatrists to label virtually any behavior as a mental disorder.

Article 5A, chapter 122 of the North Carolina General Statutes requires several independent evaluations in the commitment process, including two by physicians. There is one explicit exception to this procedure: N.C. Gen. Stat. § 122-58.18 provides for the omission of the community physician evaluation in situations in which delays for that evaluation would result in damage to life or property. See notes 121-27 and accompanying text *infra*.

Nevertheless, some judges continue to exceed their statutory authority by directly ordering hospitals to accept criminal defendants who do not fall under this provision. With the advent of the associate attorney general representing the State's interests at the four state mental hospitals, the problem has decreased significantly but still occurs occasionally. Examples include minors sent directly from juvenile court to hospitals on judicial orders that are not authorized by statute; this has been deemed improper by the North Carolina Attorney General. See, e.g., *Opinion of the Attorney General to Judge Linwood Peoples*, 45 N.C.A.G. 147 (Nov. 28, 1975).

In another case in which one of the authors was personally involved, an alleged alcoholic was sent from jail (where he had been for more than a week; he was, therefore, sober and in no danger of experiencing any alcohol withdrawal symptoms) to our hospital on a bench order stating, "Confine Mr. [X] in the John Umstead Jail for 30 days." Not only is such an order illegal, but also it seriously jeopardizes working relationships with the legal system. Clinicians do not relish the role of incarcerators, an inevitable part of involuntary commitment; that role becomes tolerable only when there is justification in the provision of needed and effective treatment for the committed patients. To be forced to accept, under penalty of contempt of court, a person with no discernable mental illness, no inebriety and no wish for treatment, is an affront to professional standards. Clinicians find it perplexing to be accused of violating the rights of their patients while legal professionals misuse the laws with which they are expected to be familiar. See also notes 37, 116 & 143 and accompanying text *infra*.

11. Johnson, *supra* note 6, at 550; Ross, *supra* note 6, at 956; Shah, *Some Interactions of Law and Mental Health in the Handling of Social Deviance*, 23 *Cath. U.L. Rev.* 674, 677 (1974). Thomas Szasz, *supra* note 10, at 24, argues the unreliability of psychiatric diagnoses generally. See also Dix, *The Role of the Lawyer in Proceedings Under the Texas Mental Health Code*, 39 *Texas B.J.* 986 (1976); Ellwanger, *Involuntary Hospitalization of the Mentally Ill Under Florida's Baker Act: Procedural Due Process and the Role of the Attorney*, 26 *U. Fla. L. Rev.* 524 (1974).

12. Johnson, *supra* note 6, at 525; Ross, *supra* note 6, at 956; Shah, *supra* note 11, at 675; New York Civil Liberties Union, *Objections to Involuntary Admission to Mental Hospitals*, 58 *Psychoanalytic Rev.* 386 (1971); *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 *Harv. L. Rev.* 1190, 1222 (1974); Comment, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework*, 84 *Yale L.J.* 1540, 1552 (1975).

13. Cohen, *supra* note 6, at 434, reports a study in which 45% of family members sought commitment for custodial or medical care that they could not provide rather than treatment for their relatives' mental problems. Thomas Szasz argues that even admissions classified as voluntary often are coerced by family members with the cooperation of physicians. Szasz, *Voluntary Mental Hospitalization: An Unacknowledged Practice of Medical Fraud*, 287 *New Eng. J. Med.* 277 (1972). See also Livermore, Malmquist & Meehl, *On the Justification for Civil Commitment*, 117 *U. Pa. L. Rev.* 15, 87 (1968); Rachlin, Pam & Milton, *Civil Liberties Versus Involuntary*

munities that wished to be free of nuisances,¹⁴ and prosecutors who wished to incarcerate criminal defendants without having to produce sufficient evidence to convict them in an open trial,¹⁵ by concurring with recommendations for commitment that were in reality sentences to mental institutions.

The initial wave of reform resulted from court cases brought by the fledgling mental health bar.¹⁶ There were three main areas of change. First, courts held that the existing commitment laws and practices violated the fourteenth amendment guarantee that liberty could not be taken without due process of law and required legislatures to provide adversary counsel at all phases of the commitment process.¹⁷ Second, the existing criteria for commitment were held to be too vague, and the almost blanket *parens patriae* justification too broad. Dangerousness to self or others was held to be a necessary criterion for commitment.¹⁸ Finally, while unwilling to create a constitutional right to treatment per se, courts held that since a statutory justification for commit-

Hospitalization, 132 Am. J. Psychiatry 189 (1975); Patients' Families Protest Liberal Laws on Commitment, *Psychiatric News*, July 18, 1973, at 3.

14. The late Jonas Robitscher, an attorney as well as a psychiatrist, recently published a book generally critical of psychiatry, *The Powers of Psychiatry* (1980). He discusses in depth the psychiatrist's role as an agent of social control. *Id.* at 326. Earlier, researchers Bentz and Edgerton found that 70% of the rural population saw the chief function of involuntary commitment as protection from the disruptive behavior of mental patients. Bentz & Edgerton, *Consensus on Attitudes Toward Mental Illness Between Leaders and the General Public in a Rural Community*, 22 *Archives Gen. Psychiatry* 468, 470 (1970). See also Livermore, Malmquist & Meehl, *supra* note 13, at 84; Maisel, *supra* note 10, at 357; Shah, *supra* note 11, at 778; Steadman, *supra* note 10, at 264.

15. Alan Dershowitz discusses two cases in which defendants were committed because prosecutors lacked evidence to secure convictions: *Hamrick v. State*, 281 Ala. 150, 199 So. 2d 849, (a case of rape without any evidence against the defendant in which the sexual psychopath statutes were used to provide a mechanism for confinement), appeal dismissed, 389 U.S. 10 (1967); and *Dodd v. Hughes*, 81 Nev. 43, 398 P.2d 540 (1965) (in which psychiatrists had predicted future violent behavior on the basis of the very criminal charges that could not be proved in court). Dershowitz, *Preventive Confinement: A Suggested Framework for Constitutional Analysis*, 51 *Tex. L. Rev.* 1289, 1290 (1973). See also Steadman, *supra* note 10, at 263. Bruce Ennis, Director of the Mental Health Law Project, and Seymour Halleck, a noted forensic psychiatrist, also discuss this issue in detail. See B. Ennis, *Prisoners of Psychiatry: Mental Patients, Psychiatrists and the Law* (1972); S. Halleck, *Law in the Practice of Psychiatry: A Handbook for Clinicians* (1980).

16. For a historical description of the development of the mental health bar, see B. Ennis, *supra* note 15.

17. *Jackson v. Indiana*, 406 U.S. 715 (1972) (defendant found incompetent to proceed to trial cannot be confined more than a "reasonable" period of time without a full hearing); *Humphrey v. Cady*, 405 U.S. 504 (1972) (hearing required to extend an original one-year sentence under Wisconsin's Sex Crimes Act); *Specht v. Patterson*, 386 U.S. 605 (1967) (sexual offenders cannot be given indeterminate sentences without a hearing); *Baxstrom v. Herold*, 383 U.S. 107 (1966) ("end-of-term" prisoners have the same due process rights as do civilly committed patients); *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974) (a right to counsel for committed patients exists, and the attorney must assume an adversary role); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972) (patient's counsel required to be an advocate for freedom); *State ex rel. Memmel v. Mundy*, 75 Wis. 2d 276, 249 N.W.2d 573 (1977) (censuring Wisconsin's probate court system used for civil commitment, especially its lack of procedural due process, including lack of access to attorneys).

18. The United States Court of Appeals for the District of Columbia was among the first to discuss the requirement for dangerousness as a criterion for involuntary commitment. Relying on District of Columbia statutes, the court supported the necessity of a demonstration of dangerousness in *Cross v. Harris*, 418 F.2d 1095 (D.C. Cir. 1968), and in *Millard v. Harris*, 406 F.2d 964 (D.C. Cir. 1968) (a case involving sexual psychopath laws). Stronger arguments, basing requirements for dangerousness on constitutional grounds, soon were forthcoming. See *Addington v. Texas*, 441 U.S. 418 (1979); *O'Connor v. Donaldson*, 423 U.S. 563 (1975); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972).

ment was treatment as a quid pro quo for loss of liberty, one could not be confined unless treatment was actually available and offered.¹⁹ In addition, as community treatment resources developed as alternatives to the large state mental institutions that house the vast majority of committed patients, legislatures and courts began to recognize a right to treatment in the least restrictive environment. In practice this meant virtually anything other than state hospitals.²⁰

These changes coincided with a social trend towards deinstitutionalization, which led to the closing of state hospitals on the belief that adequate treatment would be provided in the patients' communities.²¹ Specific court decisions forced the discharge of large numbers of committed patients,²² and new laws restricted the numbers of new patients committed to state hospitals.²³ As dangerousness became a necessary criterion for commitment in

19. In *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966), the court held that federal statutes governing the District of Columbia (Hospitalization of the Mentally Ill Act of 1964, D.C. Code Ann. §§ 21-501 to -92 (1981)), which required treatment for persons confined as patients, must be enforced. In *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), the court held that treatment was required as a quid pro quo for confinement. In *O'Connor v. Donaldson*, 423 U.S. 563 (1975), the Supreme Court refused to find an absolute constitutional right to treatment but said that treatment must be provided if a patient is confined. See also Ennis, *Legal Rights of the Voluntary Patient*, 8 Nat'l Ass'n Private Psychiatric Hosp. 4 (1976).

20. *Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969); *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966); *Dixon v. Weinberger*, 405 F. Supp. 974 (D.D.C. 1975). In these decisions the court held that a District of Columbia statute (D.C. Code § 21-545(b) (Supp. 1966)) required treatment in the least restrictive environment. In *Shelton v. Tucker*, 364 U.S. 479, 488 (1960), the Supreme Court held that a governmental purpose (commitment) cannot be pursued by means that broadly stifle personal liberties when the end can be more narrowly achieved. The court in *Lessard*, relying on *Shelton* and *Lake* as well as other decisions, held treatment in the least restrictive environment to be required in Wisconsin. 349 F. Supp. at 1096-97. For a balanced sociological analysis of the principles and practices of the least restrictive environment concept, see generally Bachrach, *Is the Least Restrictive Environment Always the Best? Sociological and Semantic Implications*, 31 *Hosp. & Community Psychiatry* 97 (1980).

21. Many of the legal efforts at improving conditions in mental hospitals actually had as their goal the forced closing of public institutions, not their improvement. See Schwartz, *Litigating the Right to Treatment: Wyatt v. Stickney*, 25 *Hosp. & Community Psychiatry* 460 (1974). Schwartz was one of the chief attorneys representing Wyatt, and he states clearly that his goal was not to improve conditions at Bryce State Hospital, but to make it so expensive to operate that noninstitutional alternatives would be encouraged. Closing a large public facility for the mentally retarded was also the goal of plaintiffs in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981). The lower courts had held that the facility had to be closed due to the substandard conditions. *Id.* at 7-9. The Supreme Court in *Pennhurst* reversed the mandate to close on procedural grounds. *Id.* at 32. See also Note, *Mental Health: Pennhurst State School & Hospital v. Halderman: Back to the Drawing Board for the Developmentally Disabled*, 60 *N.C.L. Rev.* 1115 (1982) (this issue). For a good discussion of the results of this trend, see Cochran, *Where Is My Home? The Closing of State Mental Hospitals*, 25 *Hosp. & Community Psychiatry* 393 (1974).

22. The most famous of these decisions is *Baxstrom v. Herold*, 383 U.S. 107 (1966), which resulted in the release or transfer to less restrictive facilities of 967 patients despite the predictions by clinicians that the results would be disastrous. That these consequences did not materialize is well documented. See Steadman & Keveles, *The Community Adjustment and Criminal Activity of the Baxstrom Patients: 1966-1970*, 129 *Am. J. Psychiatry* 304 (1972); Steadman, *Follow-Up on Baxstrom Patients Returned to Hospitals for the Criminally Insane*, 130 *Am. J. Psychiatry* 317 (1973).

23. One of the first overhauls of commitment laws was California's Lanterman-Petris-Short Act, Calif. Welf. & Inst. Code §§ 5000-5404.1 (1967). For discussions of its impact (which certainly has not lived up to the expectations of its original supporters), see Chase, *Where Have All the Patients Gone?*, 2 *Hum. Behav.* 14 (1973); Klatte, Lipscomb, Rozytko & Pugh, *Changing the Legal Status of Mental Hospital Patients*, 20 *Hosp. & Community Psychiatry* 199 (1969); Lamb,

more jurisdictions, attorneys pointed to a number of studies that stated rather conclusively that neither clinicians nor anyone else could predict future dangerousness with sufficient reliability.²⁴ Thus it became even more difficult to commit respondents.

There followed a strong backlash from clinical professionals, some of whom initially had favored in theory many of the changes but had opposed the practical results of these changes. Physicians vehemently objected to the "criminalization" of the commitment process, which often forced them to testify against their patients, weakening therapeutic alliances already strained by the involuntary nature of the treatment.²⁵ The respondent's attorney was seen as allying with the "sick" part of the patient against the "healthy" part that was trying to gain ascendancy with the help of the physician and treatment.²⁶

Both sides used the results of deinstitutionalization to support their positions. Attorneys and some clinicians pointed to the successful community adaptations of many patients thought by their physicians to be incapable of living outside an institution;²⁷ other clinicians pointed to the establishment of urban psychiatric ghettos of former patients living under conditions much

Sorkin & Zusman, *Legislating Social Control of the Mentally Ill in California*, 138 Am. J. Psychiatry 334 (1981); Warren, *Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act*, 11 Law & Soc'y Rev. 629 (1977).

24. The most exhaustive review of the data establishing the psychiatrist's lack of ability to predict dangerousness is Ennis & Litwack, *supra* note 10. See also A. Stone, *Mental Health and Law: A System in Transition* 28-42 (1975); Dershowitz, *The Psychiatrist's Power in Civil Commitment: A Knife That Cuts Both Ways*, *Psychology Today*, Feb. 1969, at 47; Lewinson & Ramsay, *Dangerousness, Stress and Mental Health Evaluations*, 20 J. Health & Soc. Behav. 178 (1979); Livermore, Malmquist & Meehl, *supra* note 13, at 81; Page & Yates, *Civil Commitment and the Danger Mandate*, 18 Can. Psychiatric Ass'n J. 267 (1973); Peszke, *Is Dangerousness an Issue for Physicians in Emergency Commitment?*, 132 Am. J. Psychiatry 825 (1975); Rubin, *Prediction of Dangerousness in Mentally Ill Criminals*, 27 Archives Gen. Psychiatry 397 (1972); Shah, *Dangerousness and Civil Commitment of the Mentally Ill: Some Public Policy Considerations*, 132 Am. J. Psychiatry 501 (1975); *Developments*, *supra* note 12, at 1240.

Monahan, however, argues that predictions of violent behavior *can* be sufficiently accurate to be useful if they are made about persons in the same environment in which the predicted behavior would occur. Monahan, *Prediction Research and the Emergency Commitment of Dangerous Mentally Ill Persons: A Reconsideration*, 135 Am. J. Psychiatry 198 (1978). Thus, he states that predictions made in emergency situations in the community may well have high predictive value for imminent community behavior if hospitalization is not utilized. He views the problem as existing when predictions are made concerning patients in one environment (the hospital) regarding their possible acts in an entirely different environment (the community). *Id.* at 200.

25. See Abramson, *The Criminalization of Mentally Disordered Behavior*, 23 Hosp. & Community Psychiatry 101, 103 (1972). See generally Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 Am. J. Psychiatry 496 (1976).

26. Gove & Fain, *A Comparison of Voluntary and Committed Psychiatric Patients*, 34 Archives Gen. Psychiatry 669, 672 (1977); Miller, *Voluntary "Involuntary" Commitment—The Briar-Patch Syndrome*, 8 Bull. Am. Acad. Psychiatry & L. 305, 311 (1980).

27. J. Rittenhouse, *Without Hospitalization: An Experimental Study of Psychiatric Care in the Home* (1970); Dittmar & Franklin, *State Hospital Patients Discharged to Nursing Homes: Are Hospitals Dumping Their More Difficult Patients?*, 31 Hosp. & Community Psychiatry 251 (1980); Ennis & Litwack, *supra* note 10, at 717; Livermore, Malmquist & Meehl, *supra* note 13, at 75, 85 n.29; Mosher, Menn & Matthews, *Soteria: Evaluation of Home-Based Treatment for Schizophrenia*, 45 Am. J. Orthopsychiatry 455 (1975); Polak & Kirby, *A Model to Replace Psychiatric Hospitals*, 162 J. Nervous & Mental Disease 13 (1976); Rapoport, Lassen & Grunewald, *Evaluations and Follow-Up of State Hospital Patients Who Had Sanity Hearings*, 118 Am. J. Psychiatry 1078 (1962); Shah, *supra* note 11, at 95; Steadman, *supra* note 22; Steadman & Keveles, *supra* note 22.

worse than those of the institutions from which they had been discharged.²⁸ To counter the charges that people were "railroaded" into institutions without real need,²⁹ clinicians began to publish "horror stories" describing patients whose deterioration or death could have been prevented by the practices used prior to the changes in commitment criteria and procedures.³⁰ Attorneys claimed that the large decrease in numbers of respondents committed involuntarily proved the existence of abuses prior to legal reform.³¹ Clinicians said that this decrease resulted from changing the rules of the game to shift the concerns away from the needs of severely ill persons for treatment and towards the strict observation of due process rights to the detriment of the person's clinical rights and needs.³²

28. Aviram & Segal, *Exclusion of the Mentally Ill—Reflections on an Old Problem in a New Context*, 29 *Archives Gen. Psychiatry* 126, 128 (1973); Becker & Schulberg, *Phasing Out State Hospitals—A Psychiatric Dilemma*, 294 *New Eng. J. Med.* 255, 260 (1976); Cramer, *Report on the Current State of Deinstitutionalization: Period of Retrenchment, Commentaries on Human Service Issues* (1978); Talbott, *Avoiding the Disasters of the Past*, 30 *Hosp. & Community Psychiatry* 621, 622 (1979). See also *California Senate Report Says State Hospitals Remain Indispensable*, 25 *Hosp. & Community Psychiatry* 489 (1974).

29. Rosenhan, *In On Being Sane in Insane Places*, 179 *Sci.* 250 (1973), published one of the more widely known studies. He had nine psychology graduate students obtain admission to psychiatric hospitals by claiming a single auditory hallucination which they ceased reporting immediately after admission; all were diagnosed as schizophrenic, and some were kept almost two months. Rosenhan's claims for this "experiment" are perhaps exaggerated, but it certainly demonstrated a lack of proper evaluation by the clinicians at most of the hospitals involved. For other "natural experiments," see generally A. Deutsch, *supra* note 6; T. Szasz, *supra* note 13. See also B. Ennis, *supra* note 15; Andalman & Chambers, *supra* note 6, at 54; Cohen, *supra* note 6; Johnson, *supra* note 6, at 538; Kutner, *supra* note 7, at 383; Miller & Schwarz, *supra* note 6; Robitscher, *supra* note 14, at 10, 55, 248; Comment, *supra* note 9, at 525; *Developments*, *supra* note 12, at 1197.

30. See Treffert, *Dying With Their Rights On*, 130 *Am. J. Psychiatry* 1041 (1973), a paper that was first presented at the annual meeting of the American Psychiatric Association on May 6, 1974, and that began a trend of searching for other examples of victims of due process. These examples are also documented in Peele, Chodoff & Taub, *Involuntary Hospitalization and Treatability: Observations from the District of Columbia Experience*, 23 *Cath. U.L. Rev.* 744 (1974); Perr, *Effect of the Rennie Decision on Private Hospitalization in New Jersey: Two Case Reports*, 138 *Am. J. Psychiatry* 774 (1981); Rachlin, *With Liberty and Psychosis for All*, 48 *Psychiatric Q.* 410 (1974); Reich & Seigel, *Psychiatry Under Siege: The Chronically Mentally Ill Shuffle to Oblivion*, 3 *Psychiatric Annals* 35 (1973). See also Arens, *Due Process and the Rights of the Mentally Ill: The Strange Case of Frederick Lynch*, 13 *Cath. U.L. Rev.* 3 (1964); Bowman, *American Psychiatric Association Presidential Address*, 103 *Am. J. Psychiatry* 11, 12 (1946). There is a risk that recounting "horror stories" on both sides might simply lead to an escalation of the conflict between the legal and medical professions. It is not the authors' intention to widen the chasm, but to point out that each position can lead (and has led) to unfortunate outcomes.

31. See Dix, *Hospitalization of the Mentally Ill in Wisconsin: A Need for Reexamination*, 51 *Marq. L. Rev.* 1 (1967); Gupta, *New York's Mental Health Information Service: An Experiment in Due Process*, 25 *Rutgers L. Rev.* 405 (1971); Hiday, *The Role of Counsel in Civil Commitment: Changes, Effects, and Determinants*, 5 *J. Psychiatry & L.* 551 (Winter 1977); Kumasaka, Stokes & Gupta, *Criteria for Involuntary Hospitalization*, 26 *Archives Gen. Psychiatry* 399 (1972); Wenger & Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions*, 10 *J. Health & Soc. Behav.* 66 (1969); Zander, *supra* note 9, at 502.

32. See Ford, *The Psychiatrist's Double Bind: The Right to Refuse Medication*, 137 *Am. J. Psychiatry* 332 (1980) (written by an attorney); Gutheil, *In Search of True Freedom: Drug Refusal, Involuntary Medication, and "Rotting With Your Rights On"*, 137 *Am. J. Psychiatry* 327 (1980); Michels, *The Right to Refuse Treatment: Ethical Issues*, 32 *Hosp. & Community Psychiatry* 251 (1981); Rachlin, *One Right Too Many*, 3 *Bull. Am. Acad. Psychiatry & L.* 99 (1975); Rappeport, *Rights, paper presented at the 28th Institute of Hospital & Community Psychiatry, Sept. 20, 1976* (he coined the term "belegaled" to describe the plight he felt psychiatry had inher-

III. THE NORTH CAROLINA EXPERIENCE

Prior to 1973, North Carolina's involuntary commitment statutes and procedures were comparable to those in most other states.³³ Commitment could be initiated by certification of two physicians, by a clerk of court at a hearing, or in an emergency by either a clerk or one physician. No counsel was provided, and no court hearing or review was mandated unless a writ of habeas corpus was requested, which few patients were knowledgeable enough to do. Commitment length was indeterminate. The criteria for commitment were mental illness, mental retardation, or inebriety, plus grave disability and need for treatment.³⁴

The statutes were changed significantly in 1973, with further minor revisions in 1974 and 1975. The criteria for commitment became mental illness or inebriety (with alcohol or other drugs) plus imminent dangerousness to self or others; or mental retardation plus an associated behavior disorder rendering the person dangerous to others.³⁵ Imminent was not defined statutorily; the gravely disabled standard was replaced by the "dangerous to self" requirement.³⁶

Under the 1973-75 revisions the commitment process begins with a petitioner—any competent adult with personal knowledge of the allegedly mentally disordered person—making a statement, before a magistrate or clerk of district court, that gives evidence of mental disorder and imminent dangerousness. If the magistrate or clerk finds sufficient evidence of mental disorder and imminent dangerousness, he issues an order authorizing law enforcement personnel to take custody of the respondent for examination by a qualified physician in the community where the commitment is initiated.³⁷ If the physician

ited). See also Shah, *supra* note 11, at 99; Stone, *Recent Mental Health Litigation: A Critical Perspective*, 134 *Am. J. Psychiatry* 273 (1977).

33. The most complete survey of commitment statutes currently available is *The Mentally Disabled and the Law* (S. Brakel & R. Rock eds. 1971), published by the American Bar Foundation. This edition provides an accurate picture of commitment statutes by state as of 1970; a revised edition is expected in 1982.

34. N.C. Gen. Stat. § 122-58 (1981).

35. *Id.* § 122-58.3 (amended 1977). These statutory changes were due to court decisions such as *In re Carter*, 25 N.C. App. 442, 213 S.E.2d 409 (1975), in which "danger to self" was defined to include (but was not limited to) those mentally ill or inebriate persons who are unable to provide for their basic needs for food, clothing or shelter. See N.C. Gen. Stat. § 122-58.2 (1981).

36. "Imminent" was defined by the North Carolina Court of Appeals in *In re Salem*, 31 N.C. App. 57, 228 S.E.2d 649 (1976), to mean that a person poses a danger to himself or others in the immediate future. N.C. Gen. Stat. § 122-58.2(1) (1981) defined "dangerous to self" to include those mentally ill or inebriate persons who are unable to provide for their basic needs for food, clothing or shelter.

37. N.C. Gen. Stat. § 122-58.3(a), (b) (1981). Of the four persons involved in the process of involuntary admission to a psychiatric hospital in North Carolina, only the magistrate is a legal professional; magistrates receive little formal legal education, have very little contact with civil commitment (a magistrate in a county adjacent to John Umstead Hospital who sends a large number of patients to our hospital each year told the authors that commitment represents less than two percent of what she does) and yet are empowered with the authority of a judge.

In two counties adjoining John Umstead Hospital, magistrates interpret their roles (and apparently the law) in very different ways. In one, a magistrate admitted that he never turned down a petitioner's request for commitment since he felt that he had a responsibility to the community to protect it from "sick" people as well as to protect the "sick" person from himself. Thus, he

also finds evidence to support mental disorder and imminent dangerousness,

would accept each petition from each affiant as valid. The magistrate from the other county felt quite differently. She felt that part of her role was to protect individuals from unwarranted and arbitrary decisions on the part of the family to have them "put away." The petition is presented to the magistrate *before* the prospective patient is seen by a physician, except in the case in which a physician acts as petitioner—some 10% of the cases in our recent study. Thus, she would seriously and carefully consider each petition. This latter county commits two to three times as many patients per capita and four to five times in absolute numbers monthly to our hospital as does the former, even with the higher selectivity evidenced in the latter county. Apparently, commitment as a means of resolving family difficulties is much less frequent in the former county, and the magistrate feels that there are few invalid petitions; this appears not to be the case in the latter county. The magistrate from the first county openly admitted that he knew very little about the mental health laws; further, he would frequently send patients for admission to the state university hospital without complying with the explicit provision of the statute (N.C. Gen. Stat. § 122-58.21) that requires permission of the Director of Inpatient Services at that hospital prior to such a commitment. The magistrate was unaware that his commitments were "illegal" and that they were causing considerable problems for the police charged with transportation of the patients.

There have been a number of potentially serious problems because of ignorance of the law or other deficiencies of magistrates in our area. In one case, an area magistrate refused to accept a commitment petition from the adult sister of a suicidal, drug-abusing adolescent, whose hospitalization had been strongly recommended by the local drug abuse center. The magistrate refused on the grounds that only the mother could serve as petitioner (confusing voluntary admission of a minor, which does require the participation of a parent or guardian, N.C. Gen. Stat. § 122-56.5 (1981), with involuntary commitment, which does not. See note 2 *supra*.) The mother in question refused to become involved, and as a result the suicidal girl was not admitted.

In another situation, a man brought his wife to the emergency room of a local county hospital; she was at full term of her pregnancy and allegedly had been raped the day before, with apparent rupture of her membranes (which would make the birth of her child imminent), and she was actively psychotic and self-destructive, making two serious suicide attempts while in the emergency room. One year previously, under similar circumstances except for the rape, she had miscarried and almost died. She refused voluntary admission, or even examination to check on the condition of her baby. After complicated negotiations involving three hospitals, the resident on call in the emergency room arranged for her admission to North Carolina Memorial Hospital, the only area hospital with available beds and both psychiatric and obstetrical capability. Permission for the admission was obtained from the Director of Inpatient Services, pursuant to N.C. Gen. Stat. § 122-58.21 (Supp. 1981), and the magistrate on duty agreed to the procedure. Unfortunately, by the time the patient and her husband arrived at the magistrate's office, another magistrate was on duty and refused the commitment on the grounds that he could not commit to North Carolina Memorial Hospital. Even when he was read the authorizing statute over the telephone, he refused, and simply released the woman without any further attempt to secure appropriate and possibly life-saving treatment for her. Fortunately, the patient subsequently calmed down and accepted voluntary admission to an obstetrical service the following day; however, the situation easily could have ended in miscarriage, suicide, fatal hemorrhage or a combination of the three. The district's presiding superior court judge (who appoints magistrates) and the presiding district court judge (who supervises them) were informed of the events, and were quite cooperative in immediately speaking to the magistrate and assuring us that similar problems would not recur. So far, the problems have not recurred, but there is no reason to believe that they will not.

There have been numerous other instances of problems due to magistrates' lack of knowledge of the statutes or lack of willingness to cooperate with petitioners. In the county where John Umstead Hospital is located, we had considerable difficulty for a number of years in initiating commitment petitions for patients who had been admitted voluntarily but who were demanding release. These patients were judged by the hospital staff to be severely mentally ill and to present a high risk of danger to themselves or to others. N.C. Gen. Stat. § 122-58.3 clearly authorizes hospital-initiated petitions in this situation, but the local magistrates disagreed on what they considered acceptable procedures. Some magistrates refused even to consider a petition executed by hospital staff and required a family member to be the affiant. Others would accept *only* petitions from hospital staff and would automatically reject petitions from the patient's relatives even if they had currently seen the patient in the hospital. Still others simply refused to accept *any* petitions initiated on hospitalized patients under any circumstances. This confusion hampers efforts to treat severely disturbed patients and is extremely disruptive to both the patient and the staff. The advent at the hospitals of the Associate Attorney General (AAG), who now serves as liaison between the hospital and the community legal personnel, including magistrates, has alleviated the

the respondent is then transported to a hospital approved to accept committed patients by the state Division of Mental Health, Mental Retardation, and Substance Abuse Services (hereinafter referred to as the Division). There the respondent is examined by another physician, usually a psychiatrist.³⁸ If this physician also finds evidence to support commitment, the respondent is involuntarily hospitalized pending a district court hearing required to be held within ten days after the respondent is taken into custody.³⁹ The statute also provides for an emergency hospitalization procedure to be used only if the delay necessary to provide for an evaluation by a community physician would result in substantial risk of injury to person or property. This procedure may be initiated by a law enforcement officer, whose written petition must indicate the evidence of the risks as well as the other criteria for commitment.⁴⁰

The district court hearing is held in the judicial district in which the hospital is located unless the respondent requests the hearing in the judicial district in which the petition was filed.⁴¹ Since 1977, hearings have been held regularly on a weekly or twice-weekly basis at each of the four state mental hospitals that treat over eighty percent of the involuntarily committed patients in the State.⁴² Most patients at those hospitals elect to have their hearings at the hospitals.⁴³

Written notice of the hearing is given to the respondent and to the petitioner⁴⁴ and an attorney is assigned in the same manner as for criminal defendants if the respondent is unable to hire private counsel.⁴⁵ The court hearing operates pursuant to rules of evidence, and the required standard of proof is clear, cogent and convincing evidence.⁴⁶ If a respondent does not satisfy the criteria for commitment, or if all the procedural matters are not in order, the judge must release the respondent.⁴⁷ If the criteria and due process requirements are satisfied, the judge may order further involuntary hospitalization, to either an inpatient or outpatient facility, for up to ninety days.⁴⁸ If the respondent's physician wishes to have the commitment period extended, written notice of a rehearing request must be filed in the office of the clerk of court for the judicial district in which the hospital is located fifteen days before

problems considerably. The AAGs are not present at night or on weekends, however, and problems continue to occur from time to time.

38. N.C. Gen. Stat. § 122-58.4, .6 (1981).

39. *Id.* § 122-58.7(a).

40. *Id.* § 122-58.18.

41. *Id.* § 122-58.7A (Supp. 1981).

42. Hiday, *Independence or Deference to Psychiatry: Has Reform Made a Difference in Civil Commitment?* (unpublished paper presented to the 5th International Congress of Law and Psychiatry, Banff, Alberta, Canada, Jan. 1981).

43. Examination of court files at John Umstead Hospital and communication with attorneys at the other three state mental hospitals reveals an average of 90% of committed patients who elect to have their hearings at the hospitals. Cf. note 69 *infra*.

44. N.C. Gen. Stat. § 122-58.5 (1981).

45. *Id.* § 122-58.7(c).

46. *Id.* § 122-58.7(i).

47. *Id.* § 122-58(a) (Supp. 1981).

48. *Id.* § 122-58.8(b).

expiration of the commitment period.⁴⁹ If the respondent continues to satisfy the criteria for commitment, the judge may extend commitment for up to 180 days. Subsequent rehearings may extend commitment for periods of one year at a time.⁵⁰

The wording of the statute in effect until 1973 required overt acts to demonstrate dangerousness; the courts initially interpreted this provision literally to mean physical acts such as attacking another person or making an actual suicide attempt.⁵¹ A subsequent revision of the statutes eliminated the reference to overt acts.⁵²

As a net result of these statutory changes, the number of respondents hospitalized involuntarily decreased somewhat, while the number of respondents committed at the district court hearings decreased significantly,⁵³ especially after the advent of full-time respondent attorneys at the four state hospitals.⁵⁴

A task force was appointed by the Division of Mental Health to make recommendations for changes in the mental health laws to the Mental Health Study Commission of the North Carolina General Assembly for its 1979 session. The task force included psychiatrists, psychologists, respondents' attorneys and representatives from the Attorney General's office. There were no patients or other consumers on the task force. One of the authors served on the task force. Changes were recommended and enacted into legislation in several areas.

It was felt that the full-time respondent attorneys in the state hospitals had an unfair advantage over their part-time adversaries, resulting in release of many respondents who might have been found to satisfy the criteria for commitment if both sides had been adequately represented.⁵⁵ Therefore, full-time Associate Attorney General positions were created at each of the State hospitals to represent the State's interests.⁵⁶ The qualifier "imminently" was felt to be vague and too restrictive, and it was removed.⁵⁷ Although the statutes expressly authorized outpatient commitment, there was no mechanism for enforcing it, and in practice it was largely worthless. The task force felt that a number of patients, especially those who did well on medication but stopped

49. *Id.* § 122-58.11(a).

50. *Id.* § 122-58.11(d), (e).

51. Law of June 25, 1963, ch. 1184, § 2, 1963 N.C. Sess. Laws 1648-49 (repealed 1973). See, e.g., *In re Doty*, 38 N.C. App. 233, 235, 247 S.E.2d 628, 629 (1978); *In re Carter*, 25 N.C. App. 442, 213 S.E.2d 409 (1975).

52. N.C. Gen. Stat. § 122-62(1) was repealed in 1973. Law of May 23, 1973, ch. 726, § 2, 1973 N.C. Sess. Laws, 1st Sess. 1079.

53. Hiday, *supra* note 31, at 558.

54. Data from North Carolina Division of Mental Health, Mental Retardation, and Substance Abuse Services [hereinafter referred to as DMH].

55. Many patients were being released because of procedural irregularities that could have been rectified by an attorney representing the hospital's position. Many of the objections and other courtroom tactics utilized by the patients' attorneys, who could afford to specialize in mental health law, could not be countered effectively by part-time adversaries.

56. N.C. Gen. Stat. § 122-58.24 (1981).

57. *Id.* § 122-58.1 to -.8 (1981 & Supp. 1981); *id.* § 122-58.11 (Supp. 1981); *id.* § 122-58.19 (1981).

taking it after discharge, could be treated successfully by community mental health centers if there were methods of enforcement.⁵⁸ After considerable discussion, including open public hearings, the procedure was redefined. Under the new procedure, a district court judge could order outpatient commitment *only* if both the inpatient facility currently treating the patient and the outpatient facility to which the patient would be committed agreed that this treatment would be the most effective method. A treatment plan formulated by both facilities would have to be presented at the hearing before the judge could order outpatient commitment.⁵⁹ Once ordered, the outpatient facility automatically would receive a copy of the commitment order.⁶⁰ If the patient failed to comply with any of the provisions of the treatment plan,⁶¹ the director of the outpatient facility could notify the Associate Attorney General at the hospital from which the patient had been committed. The Associate Attorney General then would request that the patient again be taken into custody, under the authority of the district court judge's original outpatient commitment order, and transported back to the inpatient facility.⁶² Within ten days of being taken into custody, the patient would have another district court hear-

58. The efficacy of psychotropic medication, especially long-acting forms of anti-psychotic medication, in maintaining remissions of chronic mental illnesses that otherwise would result in hospitalization has been well established. See L. Hollister, *Clinical Use of Psychotherapeutic Drugs* 13 (1975); D. Klein, R. Gittelman, F. Quitkin & A. Rifkin, *Diagnosis and Drug Treatment of Psychiatric Disorders: Adults and Children* 88-144 (2d ed. 1980); Ayd, *Haloperidol: Twenty Years' Clinical Experience*, 39 *J. Clinical Psychiatry* 807 (1978); Chien & Cole, *Depot Phenothiazine Treatment in Acute Psychosis: A Sequential Comparative Clinical Study*, 130 *Am. J. Psychiatry* 13 (1973); Davis, *Overview: Maintenance Therapy in Psychiatry: I. Schizophrenia*, 132 *Am. J. Psychiatry* 1237 (1975); Davis & Cole, *Antipsychotic Drugs*, in 5 *The American Handbook of Psychiatry* 441 (D. Freedman & J. Dyrud eds. 1975). The use of medication in a coercive fashion, even to prevent rehospitalization, raises a number of questions in light of the recent litigation concerning the nascent right to refuse treatment. Courts in the leading cases in the area, *Rogers v. Okin*, 478 F. Supp. 1342 (D. Mass. 1978), *aff'd*, 634 F.2d 650 (1st Cir. 1980) cert. granted, 451 U.S. 906 (1981); and *Rennie v. Klein*, 462 F. Supp. 1131 (D.N.J. 1978), mandate hearings before a committed patient may be compelled to take medication in nonemergency situations. Certiorari has been granted by the Supreme Court in *Rogers*, 451 U.S. 906 (1981), so the Court's decision will affect practices nationwide. Both of these cases dealt with inpatients; it is not clear how courts would deal with the prospect of coerced medication utilized with outpatients to prevent predicted deterioration that would render a patient once again actively mentally ill and dangerous to himself or others. J. Robitscher, *supra* note 14, at 361, explores the political and social control implications of forced medication with outpatients.

59. See N.C. Gen. Stat. § 122-58.8(b), (c) (Supp. 1981); *id.* § 122-58.11(d).

60. *Id.* § 122-58.8(b) (Supp. 1981).

61. *Id.* § 122-58.8(c). The provision requiring both the inpatient facility (in which the respondent is being treated) and the outpatient facility (to which he would be committed) to present a joint proposed outpatient treatment plan prior to the judge's ordering outpatient commitment was designed to serve two purposes:

(1) To ensure the cooperation of the mental health center. A number of mental health center directors originally had serious misgivings about these provisions, fearing that they would be flooded with committed patients for whom they had no treatments;

(2) To prevent judges from using outpatient commitment as a compromise between release and inpatient commitment when they felt that the evidence suggested the need for treatment but did not meet the clear, cogent and convincing standard necessary for inpatient commitment. Conversations between the authors and several district court judges who held hearings at John Umstead Hospital (conversations conducted over course of several months). It was hoped that this provision would prevent the use of outpatient commitment when the mental health professionals felt that it was not warranted.

62. *Id.*

ing under the same provisions as if he had just been involuntarily hospitalized.⁶³

The definition of "dangerousness to self" was broadened partly because of the insistence of clinicians who felt that the language should be more clinically oriented to reflect the considerations upon which physicians actually base their decisions to recommend commitment. The new definition included actions that would evidence that the person would be unable, without care, supervision and continued assistance not otherwise available, to exercise self-control, judgment and discretion in the conduct of his daily responsibilities and social relations, or to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety. A showing of behavior that is grossly irrational or of actions that the person is unable to control or of behavior grossly inappropriate to the situation or other evidence of severely impaired insight and judgment creates a prima facie inference under the statute that the person is unable to care for himself.⁶⁴

In addition to these amendments, section 35-3 of the North Carolina General Statutes, which provided for a "lunacy certificate" to establish incompetency for patients at the four state hospitals, was repealed,⁶⁵ and the definition of mental illness in minors was changed.⁶⁶ Discussion of these amendments and their effects is beyond the scope of this Article.

To study what effects, if any, the statutory changes had upon the practice of involuntary commitment of adults in North Carolina, and to evaluate current commitment practices, the authors investigated a sample of respondents committed involuntarily before and after the new statutes went into effect on October 1, 1979. The sample was composed of all adult patients who had initial district court hearings at John Umstead Hospital⁶⁷ between March 1 and August 31, 1979, and between October 1, 1979 and March 31, 1980.⁶⁸

63. *Id.*

64. *Id.* § 122-58.2(1) (1981).

65. N.C. Gen. Stat. § 35-3 (1966) had provided that upon written statement of the (medical) superintendent of one of the state mental hospitals that a patient admitted to the hospital was not competent to manage his affairs, the clerk of court in the patient's county of residence would declare the patient incompetent. This statute was challenged in the district court by the John Umstead Special Counsel (patient attorney) in connection with a rehearing for extension of the voluntary admission of an adult *non compos mentis*, see N.C. Gen. Stat. §§ 122-56.5, .7 (1981). The district court (Dist. Ct. Granville County Aug. 16, 1978) declared the statute unconstitutional, ordered the patient's competency restored and dismissed the petition for extension of hospitalization since the patient expressed a desire to leave. The State did not appeal the decision, so it is not clear how a higher court would have ruled, but upon recommendation of the Task Force and the Attorney General's Office, N.C. Gen. Stat. § 35-3 was repealed in the 1979 session of the General Assembly. Law of Mar. 16, 1979, ch. 152, § 1, 1979 N.C. Sess. Laws 153.

66. N.C. Gen. Stat. § 122-36(d) (1981).

67. The sample included both patients with mental illnesses and inebriates; there were no patients admitted involuntarily with primary diagnoses of mental retardation during the study periods, although a significant percentage of patients did have secondary diagnoses of mental retardation. Their admissions, however, did not invoke the sections of the statutes concerning mental retardation.

68. These periods were chosen to represent six-month periods before and after the implementation of the new statutes on October 1, 1979. The month of September 1979 was not surveyed for logistical reasons.

This sample was estimated to include twenty percent of all involuntary commitment hearings for adults held in the State during the study periods.⁶⁹

Information was obtained from court files,⁷⁰ hospital records,⁷¹ records of community mental health centers to which respondents had been committed,⁷² and from responses to questionnaires addressed to clinical and legal personnel involved in the commitment process during the study periods in the sixteen county area served by John Umstead Hospital. In addition, statistical information was obtained from the Division of Mental Health.

IV. RESULTS

Court and hospital records provided the following information: (1) type of admission—mental or inebriate; (2) most recent physician's evaluation prior to the court hearing;⁷³ (3) disposition of the case—release, commit to outpatient treatment, or commit to inpatient treatment.

Data on total admissions during the period under survey were obtained from records kept by the North Carolina Division of Mental Health, Mental Retardation, and Substance Abuse Services. In addition, all physicians who had been treating involuntarily committed patients during the period under study and who could be reached by the authors were sent a questionnaire inquiring into their perceptions of the effects of the 1979 changes.

All respondents admitted involuntarily to John Umstead Hospital have court hearings, even if the respondent has been released by the hospital prior to the hearing. Therefore this survey reflects all persons committed to John Umstead Hospital who had their hearings at the hospital, approximately ninety percent of committed persons.

During the two time periods under investigation, 914 persons were admitted involuntarily as mental patients to John Umstead Hospital, while 821 persons were admitted involuntarily as inebriates. There are three types of dispositional recommendations which can be made by physicians in regard to individuals who are involuntarily admitted to the hospital: release; commit to

69. Eighty percent of involuntarily committed patients in North Carolina have their district court hearings at one of the four state mental hospitals. Hiday, *Court Decisions in Civil Commitment*, 4 *Int'l J.L. & Psychiatry* 159, 161 (1981); John Umstead Hospital serves approximately 25% of the committed patients in the state facilities.

70. To protect the confidentiality of the legal files, the legal secretaries of the Special Counsel and the Associate Attorney General provided the necessary information, including the hospital physician's recommendations to the court and the outcome of the hearing, all of which is a matter of public record. Neither attorney who was practicing at John Umstead during the study periods was still there at the time the study was done.

71. The project had been approved by the John Umstead Research Committee; no patient-identifying information has been utilized, so that informed consent from those patients whose records were surveyed was not necessary (DMH, Regulations on Confidentiality of Client Records, 10 N.C. Admin. Code 18D .0319).

72. Requests for follow-up information on patients committed to outpatient treatment were addressed to area mental health centers. No identifying information was used; those centers with their own research committees approved the requests prior to responding.

73. Some records contained no physician's evaluation because the evaluation had been sent to another set of files; these records, which were not used in the study, represented less than 10% of the records after, and less than 1% of the records before, October 1, 1979.

outpatient treatment; commit to inpatient treatment. Table 1⁷⁴ indicates the recommended dispositions for all respondents involuntarily admitted to John Umstead Hospital during the times under investigation. With regard to mental patients, the percentage of involuntarily admitted persons recommended by physicians to each of the three dispositional categories is almost identical over the two time periods. The results of inebriate admissions are similar but do not show the same degree of congruence between the two periods as do the mental admissions.

Tables 2 and 3⁷⁵ show the percentage agreement between the physicians' recommendations and the final court disposition during the time periods under study. Since the numbers of outpatient commitment recommendations and dispositions were too small to yield a statistically significant result, these data were combined in the following manner: for physician recommendations to commit to inpatient treatment, a result of outpatient commitment was treated as a release for the purpose of examining the concurrence of the physician's initial recommendation with the final court disposition. Similarly, if the physician recommended release, a result of outpatient commitment was treated as a commitment for the purposes of comparison. These additions did not alter the results of the study significantly.

There appear to be significant differences in percentage agreement between physicians' recommendations and court dispositional decisions with regard to mental patients during the two time periods. From the period March 1-August 31, 1979, there is high agreement between physician and court on the recommendation to release the patient (94 percent), while there is much less agreement when the physician recommends commitment (67 percent). During the period October 1, 1979-March 31, 1980, the reverse is true. If the physician recommended commitment, there was 89 percent agreement with the court on final disposition, while if the physician recommended release, there was only 70 percent agreement with the court decision.⁷⁶

With inebriate patients, there is little difference between physician's recommendations for release and final court disposition of release in both time periods; there is a discrepancy between physician's recommendations for commitment and court release in the times under investigation (50 percent committed during March 1-August 31, 1979 as compared to 70 percent committed in the October 1, 1979-March 31, 1980 period). This difference is statistically significant between the .05 and the .02 levels of significance according to the Chi Square analysis.

The data thus indicate that while there is almost no difference between physician recommendations during the two time periods, there is a significant difference between physician recommendations and final court disposition during both of these times, and that the areas of discrepancy shift from one

74. See Table 1, Appendix *infra*.

75. See Tables 2 & 3, Appendix *infra*.

76. These differences are statistically significant at greater than the .001 level of significance according to Chi Square statistical analysis.

time period to the other. The results of the study of the outcomes of hearings for inebriates are not as significant as those for mental patients.⁷⁷

There are a number of possible explanations for the observed changes in the results of commitment hearings for mental patients after October 1979. We will examine each potential source of variation in turn.

There were no major changes in the physician staff at John Umstead Hospital during the period under investigation.⁷⁸ An opinion survey indicated that few physicians were aware of any differences in their recommendations to the court after October 1, 1979.⁷⁹

There is no reason to expect that the patient population changed significantly between the two periods under study; there were no significant differences in the total number of patients admitted to the hospital or in the number of patients admitted involuntarily.⁸⁰ John Umstead, similar to many state mental hospitals, serves a number of chronically mentally ill patients who have multiple admissions; 68 percent of patients admitted to John Umstead in the period of the study were readmissions.⁸¹ This factor lends a certain stability to the patient population. Neither the psychiatrists at John Umstead nor those in the community mental health centers in the Umstead catchment area felt that there were any changes in the types or severity of illness of patients committed between the two periods under study.

The panel of judges who hold commitment hearings did not change during the study period. The judges did not indicate in conversation with the authors any change in their attitudes or philosophies concerning commitment during the study period.

The 1979 revision of the North Carolina commitment statutes did include some changes in the basic criteria for commitment; dangerousness is still necessary, but the respondent no longer needs to be "imminently" dangerous.⁸²

77. A probable reason for this result is that state mental hospitals in North Carolina provide only detoxification services for alcoholics, with treatment being provided by state-operated Alcohol Rehabilitation Centers. Since detoxification is usually accomplished within three days, and the court hearings are held three to ten days after admission, most alcoholics are no longer in need of hospitalization by the time of the hearing and are recommended for release by the physicians.

Also, community pressure to retain alcoholics in the hospital is not as great as with mental patients; alcoholics' behavior outside the hospital is generally less unacceptable than that of mental patients, and alcoholics' families do not appear to come to court as often to testify for their commitment. Even so, the percentage of cases in which the court concurred with the physicians' recommendations for commitment of alcoholics increased by the same amount after October 1979 as did the concurrence for commitment of mental patients. A major difference between inebriates and mental patients is that the percentage for which the court concurred with recommendations for release did not change appreciably after October 1979.

78. There was one new physician out of a total hospital staff of 37 physicians.

79. This perception is substantiated by the data that show that the physicians recommended inpatient commitment for 359 of 462 respondents admitted involuntarily (78%) before and 348 of 452 (77%) after October 1979. Outpatient commitment was recommended for 14 of 462 (3%) before and 13 of 452 (3%) after; recommendations for release were made for 89 of 462 (19%) before and 91 of 452 (20%) after. See Table 1, Appendix *infra*.

80. Statistical data furnished by DMH.

81. Holden, *Mental Hospitals of North Carolina*, Task Force on Deinstitutionalization, North Carolina Governor's Conference on Mental Health, Raleigh, 1979.

82. N.C. Gen. Stat. § 122-58.1 (1981).

Diminished judgment and capacity to make important decisions were also added to the definitions of danger to self.⁸³ The Division of Mental Health Task Force predicted these changes would make it easier to commit patients, and the percentage of patients committed at hearings at John Umstead Hospital has certainly increased since the new statutes took effect. The broader criteria for committability do not explain the reversal in concurrence between physician recommendations and court results. Nor do the arguments in the court hearings reflect the changes in the language of the statutes. The results of the physician survey indicate that there were no major changes in the pattern of physician recommendations to the court because of the changes in the language of the statute.⁸⁴

If the differences in the outcome were the result of changes in the wording of the statute, changes in physicians' recommendations to the court, differences in the population at risk for commitment, or differences in judges' opinions, then the major source of variation must have been the attorneys at the hearings. In fact, the observed differences are entirely consistent with the changes in roles and philosophies of the attorneys, and can be satisfactorily explained on that basis.

Prior to October 1979, the counsel for the patients (Special Counsel) at John Umstead Hospital defined her role (which is not defined statutorily beyond "to represent respondents in commitment hearings") as that of an advocate for freedom. She assumed that, even if a patient told her specifically that he desired to be committed, he actually desired to be released at the hearing. She raised numerous due process objections to patients' commitments, demonstrated by the fact that 49 percent of the releases were due solely to inadequacies of the petition or other paperwork executed prior to hospitalization.⁸⁵

Her adversary at John Umstead Hospital, the Special Advocate, usually had no opportunity to contact petitioners, magistrates, or others from the community who had been involved in the commitment process. Therefore, she was unable to develop testimony relevant to her case, rectify correctable errors, or work with magistrates to improve the quality of the commitment

83. *Id.* § 122-58.2(1) (1981).

84. Questionnaires were received from 16 of the 21 adult psychiatrists who were at the hospital during the study period and who could be contacted. Of those 16, 10 said that they had not made any changes in their patterns of recommendation to the court; three said they had begun recommending commitment for more patients after the statutory change; and two said that they were recommending commitment for fewer patients, resulting in no significant net changes in patterns of recommendation. In addition, the statistics on the numbers of recommendations also document the lack of change in recommendation patterns. See Table 2, Appendix *infra*.

85. Of the 103 respondents released against physicians' recommendations at the hearings during the period in question, 50 (49%) were released because of technical irregularities on the original petitions. In addition, another 15 (15%) were talked into signing requests for voluntary admission despite statements in their physicians' affidavits that voluntary admission was not clinically indicated and despite the lack of power by Special Counsel to enter into a treatment contract with patients, particularly without the knowledge of the physician. The "voluntary admission" was therefore not binding on either the patient or the hospital; and many of the patients demanded their release immediately after the hearings. But Special Counsel was still able to use this maneuver both to convince the judge that the respondents would get the treatment that they needed without having to be committed and to secure the release of the respondents from their commitments.

paperwork coming from the community. In addition, the Special Advocate who served during the March-August 1979 period defined her role as that of representing the hospital's position.

It is therefore understandable that a number of respondents recommended for commitment were released, often as a result of procedural objections that did not take into account the physicians' recommendations. It is also understandable that patients recommended for release were in fact released, since neither counsel would object to the release. The judges in the hearings have typically been passive, responding to the arguments of the attorneys rather than conducting their own examinations.⁸⁶ They seldom differed from a position held jointly by both counsel.

After October 1, 1979, there were two significant changes: the previous Special Counsel resigned and was replaced; and the full-time Associate Attorney General (AAG) replaced the part-time Special Advocate. The new Special Counsel defined her role as serving in the best interests of her clients, which she sometimes determined to be commitment even if the client requested release.⁸⁷ In addition, she chose to raise few objections to commit-

86. Statewide surveys, concluded by Virginia Hiday with regular courtroom observers, have demonstrated that judges ask questions in fewer than 20% of the hearings. Hiday, *supra* note 69, at 165-66. The authors' observations in court hearings at John Umstead Hospital are that judges participate in even fewer cases.

87. There is considerable controversy in the literature concerning the proper role of attorneys in the civil commitment area. Most authors argue strongly in favor of a true adversarial role, with respondents' attorneys representing their clients' expressed wishes. Andalman & Chambers, *supra* note 6, at 75; Blinick, *Mental Disability, Legal Ethics, and Professional Responsibility*, 33 *Alb. L. Rev.* 92, 111 (1968); Cyr, *The Role and Functions of the Attorney in the Civil Commitment Process: The District of Columbia's Approach*, 6 *J. Psychiatry & L.* 107, 121 (1978); Dix, *supra* note 11, at 984; Gupta, *supra* note 6, at 450; Johnson, *supra* note 31, at 566; Kirkpatrick, *Oregon's New Mental Commitment Statute: The Expanded Responsibilities of Courts and Counsel*, 53 *Or. L. Rev.* 245, 251 (1974); Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 *Calif. L. Rev.* 816, 827 (1974); Zander, *supra* note 9, at 513; *Developments, supra* note 12, at 1288; *Special Project, Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation*, 64 *Iowa L. Rev.* 1284, 1390 (1979); *Projects, supra* note 6, at 854; *Comment, supra* note 12, at 1560.

Many attorneys prefer the "best interests" role in dealing with respondents involved in civil commitment procedures. Perhaps the most eloquent legal defense of this philosophy is Lawrence Galie's, in *An Essay on the Civil Commitment Lawyer: Or How I Learned to Hate the Adversary System*, 6 *J. Psychiatry & L.* 71 (1978). In practice, many attorneys assigned to represent respondents have seen their role as representing the respondents' best interests, which might not always coincide with their stated requests. The best interests role is discussed, but not advocated, in R. Rock, M. Jacobson & R. Janopaul, *Hospitalization and Discharge of the Mentally Ill* 165 (1968); Andalman & Chambers, *supra* note 6, at 48, 59; Cohen, *supra* note 6, at 445, 450; Cyr, *supra* note 87, at 109; Dix, *supra* note 9, at 190; Wexler & Scoville, *supra* note 6, at 53; Zander, *supra* note 9, at 516; *Contemporary Studies Project: Facts and Fallacies About Iowa Civil Commitment*, 55 *Iowa L. Rev.* 895, 912, 923 (1973).

The court cases in the area have changed directions in the past decade. One group of cases examined the right to have counsel during commitment proceedings, without dealing with the role of the attorney. See, e.g., *Heryford v. Parker*, 396 F.2d 393 (10th Cir. 1968) (anyone subject to incarceration for any purpose has a right to an attorney at all stages of the process); *State v. Collman*, 9 Or. App. 476, 497 P.2d 1233 (1972) (supporting right to counsel); *State ex rel. Memmel v. Mundy*, 75 Wis. 2d 276, 283, 249 N.W.2d 573, 577 (1977) (in which court attacked the Wisconsin probate court's system for commitment for not providing effective counsel, but not dealing with the issue of counsel's role, even after the *Lessard v. Schmidt* decision). The best interests model was upheld in *In re Basso*, 299 F.2d 933 (D.C. Cir. 1962), in which the court denied an appeal based on a charge of ineffective assistance of counsel when a respondent attorney sup-

ment based on technical procedural irregularities. She concentrated instead on substantive issues concerning the respondents' conditions at the time of the hearing as well as major violations of due process, such as a lack of evidence for mental illness or dangerousness in the original petition or medical evaluation.

The AAG, by not consistently advocating either for or against commitment, and by specifically encouraging petitioners (usually family members) to attend the hearing when their wishes differed from the recommendations of the physicians, reinforced the swing of the pendulum from favoring release to favoring commitment.⁸⁸ The present situation differs significantly from that prior to 1973, when respondents had little access to consistent, knowledgeable counsel, and physicians' recommendations for commitment were ratified frequently. Now, respondents are being committed *against* physician recommendations, a unique situation in the area of involuntary commitment.⁸⁹ According to North Carolina statutes, physicians may release committed patients at any time, regardless of the court's decisions.⁹⁰ In practice, however, physicians are reluctant to discharge patients too soon after they have been

ported commitment for a protesting patient. See also *Prochaska v. Brinegar*, 251 Iowa 834, 102 N.W.2d 870 (1960) (court upheld best interests test); *People ex rel. Rogers v. Stanley*, 17 N.Y.2d 256, 260-64, 217 N.E.2d 636, 636-39, 270 N.Y.S.2d 573, 575-78 (1966) (Bergan, J., dissenting, favoring best interests role).

Later cases have tended to support an active adversarial role. See *Anders v. California*, 386 U.S. 738, 744 (1967); *Lessard v. Schmidt*, 349 F. Supp. at 1098 (mentally ill person is entitled to "representative counsel" who views his role as a "defense counsel" and as an "advocate for freedom"); *In re Quesnell*, 83 Wash. 2d 224, 517 P.2d 568 (1978); *State ex rel. Hawks v. Lazaro*, 202 S.E.2d 109 (W. Va. 1974) (court rejected arguments of *Basso* and held that an attorney who waived his client's presence at the hearing, failed to discuss the case with his client and did not oppose commitment had been so ineffective that client's due process rights were violated).

88. Families' differences with physician recommendations were almost invariably in the direction of favoring commitment when the physicians had recommended release. Occasionally petitioners would change their minds after visiting the patient in the hospital or because of unwillingness to testify for commitment in front of the patient, but these cases represent a small percentage of hearings.

89. There are few references in the literature to judges committing respondents despite physician recommendations for release, and none documenting a significant number of such commitments. Maisel, *supra* note 10, at 358, mentions that "[s]everal patients were committed against the recommendations of the hospital because they could not satisfy the judge about the stability or propriety of their future plans." Most authors report that judges' concurrence with psychiatric recommendations for release is essentially 100%. See Hiday, *Reformed Commitment Procedures: An Empirical Study in the Courtroom*, 11 *Law & Soc'y Rev.* 664 (1977), a study conducted in North Carolina. She states, "Judges generally felt that such a recommendation [for release] eliminated any cause for commitment, and consequently dismissed the case." *Id.* at 660. Colorado law, as reported by Johnson, requires the judge to release a patient upon "a satisfactory showing [as by medical reports] that the respondent has received maximum benefit from treatment, that he is mentally competent, and that it would be in his best interest to be released." Johnson, *supra* note 6, at 540.

90. N.C. Gen. Stat. § 122-58.13 (1981) requires the chief of medical services of a facility that accepts involuntarily committed patients to "discharge a committed respondent unconditionally at any time he determines that the patient is no longer in need of hospitalization." The only exception is a new provision that went into effect July 1, 1981 (see N.C. Gen. Stat. §§ 122-58.8(b), -58.11(a), -58.11(a1), -58.11(e), -58.13) (Supp. 1981)) and requires that patients committed after having been found not competent to proceed to trial or not guilty by reason of insanity may not be released from hospitalization without judicial review. Clinicians have generally supported this change because it provides protection from liability arising from acts committed by presumptively dangerous patients released from their commitment prematurely.

committed by the court, because of strong and immediate adverse community reaction from families and mental health centers and because of potential liability for actions of patients released in the face of commitment decisions by the court.⁹¹

The judges on the panel who hear commitment cases at John Umstead, while not changing their basic philosophies, also responded to the changes in attorneys' positions. Prior to October 1979, they frequently would grant petitions to release respondents based on procedural irregularities, especially after the Special Counsel had appealed and won several cases in which procedural objections had been overruled.⁹² After the changes in attorneys, the judges

91. There have been no suits against psychiatrists in North Carolina based upon premature release of committed patients, but there have been several liability suits elsewhere. See *Tarasoff v. Regents of the University of California*, 17 Cal. 3d 425, 521 P.2d 334, 131 Cal. Rptr. 14 (1976); and *McIntosh v. Milano*, 168 N.J. Super. 466, 403 A.2d 500 (1979), in which courts held that therapists were responsible for harm inflicted by their patients because they had not warned the threatened victim or had not taken sufficient action to prevent the harm that reasonably could have been predicted.

A number of courts have imposed liability upon hospital staffs for negligently releasing patients without adequately evaluating them to determine the presence of risks to others if released. See *Underwood v. United States*, 356 F.2d 92 (5th Cir. 1966); *Fair v. United States*, 234 F.2d 288 (5th Cir. 1956); *Williams v. United States*, 460 F. Supp. 1040 (D.S.C. 1978); *Merchants Nat'l Bank & Trust Co. v. United States*, 272 F. Supp. 409 (D.N.D. 1967).

92. The most significant appeals court decision came in *In re Farrow*, 41 N.C. App. 680, 255 S.E.2d 777 (1979). In that case, respondent appealed the commitment ordered by the district court of Granville County (No. 78SP160) on two grounds: (1) The petition was filed by the attending physician of the respondent, who was a voluntary patient at John Umstead Hospital at the time the petition was filed. Respondent objected to the use of information gathered in the course of a confidential physician-patient relationship as the basis for the magistrate's custody order, and as the basis for the same physician's affidavit that was introduced into evidence at the commitment hearing. Respondent alleged that without her consent (which was not forthcoming), N.C. Gen. Stat. § 8-53 (dealing with the confidentiality of the doctor-patient relationship) prohibits disclosure of confidential information without consent of the patient. See N.C. Gen. Stat. § 8-53 (1981). The court held that N.C. Gen. Stat. § 8-53 is not applicable in involuntary commitment proceedings due to the perceived legislative intent for the attending physician to play a key role throughout the commitment process. Appeal on the first ground was denied. 41 N.C. App. at 683, 255 S.E.2d at 779.

(2) Respondent also objected to the initiation of involuntary proceedings for a patient who had sought voluntary admission and who gave no evidence of intent to leave the hospital. The commitment order had been sought in order to allow the patient to be transferred to a more secure unit within the hospital, which would permit greater staff contact and prevent the suicidal acts that were occurring on her present ward. Respondent had not objected to her transfer, or indeed to any of her treatment plan, but the accepting unit had a policy of accepting only involuntarily committed patients. Hence, commitment proceedings had been initiated. The court held that the legislature's intent was to encourage voluntary admissions (N.C. Gen. Stat. § 122-56.1 (1981): "It is the policy of the State to encourage voluntary admission to treatment facilities . . ."). Absent a showing that respondent had given evidence of intent to leave the hospital or that commitment was "reasonably necessary for the effective treatment and safety of the patient or for the safety of others," the court held that a voluntarily admitted patient may not be held involuntarily. 41 N.C. App. at 686-87, 255 S.E.2d at 782. The original commitment order was therefore reversed.

As a result of this case, the special unit's requirement for involuntary status was changed. The ruling has caused subsequent problems, however. N.C. Gen. Stat. § 122-58.6(c) provides that "pending the district court hearing, the qualified physician attending the respondent is authorized to administer to the respondent reasonable and appropriate medication and treatment that is consistent with accepted medical standards." The Attorney General has ruled that this provision also logically applies to committed patients after their district court hearings. Personal communication to the authors from the Deputy Attorney General for Mental Health. By contrast, voluntary patients in all fields of medicine, including psychiatry, almost always have had the right to refuse treatment, absent conditions such as unconsciousness or emergencies that clearly render them

were not faced with many due process objections but rather were presented for the first time with frequent and strong community opinions in favor of commitment. Prior to October 1979, petitioners usually came to the hearings only when the hospital staff asked them to come to bolster the staff recommendations for commitment. In addition, there had been a strong negative community reaction to the increase in court releases of respondents despite physician recommendation for commitment during the period of 1977-1979.⁹³ The judges were quite sensitive to this pressure.

The retrospective data do not reveal the presence or absence of lay witnesses at hearings or the nature of their testimonies. Thus, a conclusive causal link between the presence of lay witnesses and the increase in commitments against physician recommendations cannot be definitely established at this point, although the opinions of the authors and the Special Counsel and AAG at the time support this conclusion.⁹⁴

In addition, it appears that the effect of lay witnesses has been opposite to that predicted,⁹⁵ increasing rather than decreasing the commitment rate. As

incapable of making a competent refusal. (See *contra*, *In re President and Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964) (forced blood transfusion)). District court judges sitting at hearings at John Umstead Hospital have applied the *Farrow* decision broadly in cases concerning voluntarily admitted patients who were not requesting discharge but were refusing clinically indicated treatment.

In one case in which the authors were personally involved, a young woman suffering from a psychotic illness requested voluntary admission for treatment of her psychosis. She initially accepted medication but subsequently refused, believing that the drugs were part of a secret plot to poison and destroy her. Her condition deteriorated seriously; she became hostile and more psychotic, and she refused to eat or drink anything for fear of poison, to the point that she became clinically dehydrated and in some medical danger. She did not request discharge but continued to refuse all treatment for her potentially life-threatening condition. She clearly met all the criteria for commitment, and the staff felt that commitment was "reasonably necessary for the effective treatment and safety of the patient," because we could not initiate any effective treatment so long as she was a voluntary patient. Both the Special Counsel and the Associate Attorney General agreed that she should be subject to commitment and raised no objections. The judge (whose original commitment order in *Farrow* had been reversed) raised the objection himself and refused to commit the patient. Eventually we had to discharge the patient and then re-commit her from outside the hospital to allow her to be treated effectively.

93. With the sharp increase in court-ordered releases resulting from the efforts of Special Counsel, our hospital began to receive a number of complaints from mental health centers and patients' families concerning what they perceived as premature releases from commitment. Each of these complaints was investigated, and in the large majority of cases, the release had been ordered by the court against the recommendation of the hospital staff. With the advent of the Associate Attorney General, these community members were effectively informed of the hearings and had an avenue for expression of their feelings.

94. There is some support for the concept that family preferences have a significant impact upon the outcomes of commitment hearings. See H. Steadman & J. Cocozza, *Careers of the Criminally Insane: Excessive Social Control of Deviance* 125-27 (1974); Blinick, *supra* note 87, at 98; Doll, *Family Coping With the Mentally Ill: An Unanticipated Problem of Deinstitutionalization*, 27 *Hosp. & Community Psychiatry* 183 (1976); Greenley, *Alternate Views of the Psychiatrist's Role*, 20 *Soc. Probs.* 252 (1972); Rachlin, Pam & Milton, *supra* note 13, at 190-91; Warren, *supra* note 23, at 636; Zander, *supra* note 9, at 551. These writers make general statements that imply that families' wishes have an impact on the process of commitment and release.

95. Many of the authors critical of the absence of adversarial counsel for respondents list as a major duty of such an attorney the interviewing of relatives and other community persons and the presentation of their evidence at the hearing. This view presupposes that their testimony would be favorable to release of the respondent. See Andalman & Chambers, *supra* note 6; Cohen, *supra* note 6; Wexler & Scoville, *supra* note 6; Projects, *supra* note 6.

discussed in the conclusion of this Article, this finding may be evidence of a trend in society back toward sequestration of the mentally disordered rather than normalization of their lives in society.

Another question raised by these results is the use of the adversary system in the commitment process. Most of the legal advocates and clinical opponents of this system see it not as a balanced system designed to ensure that the positions both for and against commitment are represented in order to facilitate decisionmaking, but as a one-sided legal force for release to counterbalance what has been perceived as the unopposed power of clinical professionals to impose their opinions on the courts and on their patients.⁹⁶ There has been mention of the lack of equal legal representation to oppose respondent attorneys, but little concern has been expressed over these findings.⁹⁷ Yet no one suggests that we do away with prosecuting attorneys in criminal trials, or accuses judges of undue deference to prosecutors, even though the conviction rate in criminal trials remains higher than the commitment rates in jurisdictions with effective respondent attorneys. The weight of the state's authority is at least as great in criminal trials as in commitment cases. The thrust in much of the legal and social literature seems to be toward abolition of involuntary treatment, not toward its judicious use, which is as extreme a position as that taken by clinicians who would recognize few rights for their patients.⁹⁸

The ethical prohibition against conflict of interests is another cornerstone of the criminal justice system which has not left the transition to the civil commitment system unscathed.⁹⁹ Just as psychiatrists are accused of being

96. One commentator argues that if the petitioner is not represented by counsel, then the judge will automatically, though perhaps unconsciously, provide a counterweight to the respondent's attorney. It is also suggested that even an unopposed respondent's attorney will be "hard pressed to defeat an unrepresented petitioner or overcome the testimony of petitioner's psychiatrist." Comment, *supra* note 12, at 1557. Johnson states that "[s]hould the patient succeed in obtaining adequate representation, he still faces the problem of marshalling evidence beneficial to his case. The state automatically has at its disposal a plethora of evidence to support its objection to release." Johnson, *supra* note 6, at 525. See also Brunetti, *supra* note 7, at 695 (noting Supreme Court's view that even without an attorney for petitioner or the state, a respondent cannot rely on the good will of the petitioners, doctors and judge and therefore needs independent representation). Our experience in North Carolina has not borne out these views; when faced with active legal representation and without adequate counsel for the state, physicians are at a great disadvantage in the courtroom.

97. Brunetti, *supra* note 7, at 694; Cohen, *supra* note 6, at 448; Gupta, *supra* note 31, at 432; Johnson, *supra* note 6, at 545; Zander, *supra* note 9, at 520; Developments, *supra* note 12, at 1288. On the other hand, Alan Stone, past president of the American Psychiatric Association, states, "The last decade has made it clear the psychiatrists are anything but a powerful adversary. Whenever the mental health advocate pressed, the psychiatric profession gave way. In the court rooms, there was almost never a zealous legal advocate to oppose the self-appointed patient advocate." Stone, *The Myth of Advocacy*, 30 *Hosp. & Community Psychiatry* 820 (1979).

98. See B. Ennis, *supra* note 15; Livermore, Malmquist & Meehl, *supra* note 13; New York Civil Liberties Union, *supra* note 12; Projects, *supra* note 6. Other authors would support such strict legal protections for committed patients and for hospitals which accept them that their recommendations would have the practical effect of eliminating commitment. See Ennis & Litwack, *supra* note 10; Schwartz, *supra* note 21. Many of these authors have taken their lead from psychiatrist Thomas Szasz. See T. Szasz, *supra* note 10, whose works are liberally quoted throughout their papers.

99. Litwack, *supra* note 87, at 834, raises the question of conflict of interest in reference to the dual role as patient advocate and reporter to the court. See note 100 and accompanying text *infra*. Canon 5 of the ABA Code of Professional Responsibility would seem to forbid simultaneous or

"double agents," attempting to serve both the state and their patients even when the two interests are opposed,¹⁰⁰ the statutory roles for attorneys involved with civil commitment also create conflicts. New York's Mental Health Information System, often held up as an early model of the beneficial effects of respondent attorneys, forces its attorneys both to defend clients before and during hearings and to furnish to the court complete reports concerning their clients that often contain information detrimental to the clients' wishes for release.¹⁰¹ The role of the AAG in the current North Carolina system is even more confused. It is defined statutorily as "represent[ing] the State's interest,"¹⁰² which has been amplified by the Attorney General's office to include the interests of both the petitioners and the hospital staff, whose opinions are frequently in conflict.¹⁰³ If the respondent attorney's role is to be, as has been suggested, an "advocate for freedom,"¹⁰⁴ then a truly adversarial system would require that the opposing state's attorney be an advocate for commitment.¹⁰⁵ This adversarial structure would not preclude pretrial negotiation, as happens in the majority of criminal cases, and it would provide each interested party—the respondent, the petitioner, other interested lay witnesses, and the hospital staff—access to an advocate for their positions.

The data that we have collected seriously challenge some long-held assumptions in the legal literature, such as the belief that judges and courts display excessive deference to psychiatric opinions in favor of commitment,¹⁰⁶

successive representation of conflicting interests except by express consent of all concerned given after a full disclosure of relevant facts. See Model Code of Professional Responsibility, Canon 5 (1979). Blinick discusses potential conflicts of interest for attorneys who attempt to represent both the respondent and his or her family; no one has discussed the issues of potential conflict of interest for attorneys for the state or the petitioner. Blinick, *supra* note 87, at 97.

100. S. Halleck, *Psychiatry and the Dilemmas of Crime* (1967); S. Halleck, *supra* note 10, at 145; J. Robitscher, *supra* note 14, at 41; Bassiouni, *supra* note 7, at 304; Caldwell, *supra* note 9, at 530; Ross, *supra* note 6, at 964; Shah, *supra* note 11, at 680; Szasz, *The Psychiatrist as Double Agent*, *Trans-Action*, Oct. 1967, at 16. See generally Steadman, *supra* note 10.

101. See discussion at note 92 *supra*.

102. N.C. Gen. Stat. § 122-58.24 (1981).

103. Deputy Attorney General for Mental Health, Report to the Medical Staff of John Umstead Hospital, Nov. 7, 1980. The pressure to reduce the population at public hospitals has increased due to a combination of dwindling funds, the deinstitutionalization movement and requirements from accrediting bodies for increased staff/patient ratios (which can most cheaply be achieved by decreasing the number of patients). In response to these developments, psychiatrists have begun to recommend earlier discharge for many patients, often by the time of the district court hearing within ten days of admission. Petitioners frequently feel that this is too short a time in which to realize the *petitioners'* objectives (often a simple respite from having to deal with respondents who are disturbed, but not sufficiently so to meet the more stringent commitment criteria). There are also situations in which petitioners, especially family members, change their minds about their requests for commitment, especially if the patient threatens them or if they have to face the person in court. Many petitioners hope that the respondent will not discover the identity of the person who initiated the petition; many of these petitioners will deny having executed the petition that bears their signatures once they get into court.

104. *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972).

105. This structure is analogous to the criminal system, in which the state's interest lies in obtaining a conviction, and lay citizens who initiate criminal proceedings are not allowed to withdraw their complaints, at least in serious crimes. See Miller & Fiddleman, *The Adversary System in Civil Commitment of the Mentally Ill: Does It Exist and Does It Work?*, 9 *J. Psychiatry & L.*, No. 4 (1981).

106. See note 10 *supra*.

that the presence of active attorneys would lead automatically to decrease in commitments,¹⁰⁷ and that the increased presence of lay witnesses would also lead to a decrease in commitments.¹⁰⁸

For a variety of reasons, mental hospitals are under considerable pressure to decrease the number of resident patients.¹⁰⁹ Increases in required staff-patient ratios, the availability of effective treatments for many of the most severe mental disorders, and continued pressure from attorneys and courts have all contributed to this trend. Because of anticipation of courtroom challenges, many hospital-based psychiatrists have become more selective in recommending commitment, often making considerable effort to convince their patients to request voluntary treatment.¹¹⁰ In the current situation, judicial concurrence with psychiatric recommendations can no longer be taken as indicating undue deference. The significant number of respondents committed against psychiatric recommendations is clear evidence of the absence of any such undue deference.¹¹¹

The major shift in commitment results between the two study periods demonstrates the impact of attorneys on the process of commitment. Where previously psychiatrists had come under attack, often justifiably, for making capricious decisions based on little contact with their patients and on personal prejudices, it now seems that some of these criticisms could be leveled equally at the attorneys involved in the process and upon the system that imposes their roles.

V. OUTPATIENT COMMITMENT

To see if the 1979 statutory changes had any effect on the actual use of outpatient commitment, we studied all adult respondents committed to outpatient treatment from John Umstead Hospital during the six-month periods before and after the new statutes went into effect. The patients' charts were surveyed to ascertain what recommendations the hospital physician had made to the court. Each mental health center to which respondents were committed during the periods of study was contacted to determine the outcome of the

107. See note 31 *supra*.

108. Cyr, *supra* note 87, at 111; Dix, *supra* note 11, at 984.

109. See note 103 *supra*.

110. An attitude survey of psychiatrists at our hospital revealed that, after the advent of the full-time Special Counsel and her success in obtaining release of a number of patients, several psychiatrists began to urge more of their patients to accept voluntary status even if initially admitted involuntarily. Gupta notes that one result of the presence of adversarial respondent attorneys at Bellevue Hospital is a significant increase in "out-of-court settlements" that include patient decisions to accept voluntary hospitalization. Gupta, *supra* note 31, at 422, 436. Gilboy & Schmidt, in "Voluntary" Hospitalization of the Mentally Ill, 66 *Nw. U.L. Rev.* 429, 436 (1971), state that many physicians in Illinois talk their patients into voluntary admissions in order to avoid the responsibility (including courtroom appearances for both their patients and themselves) of initiating involuntary commitment. Schwartz & Dumpman, in *Voluntary Commitment by Persuasion*, 23 *Hosp. & Community Psychiatry* 129 (1972), also describe increased efforts to convince patients to accept voluntary hospitalization following passage of a stricter involuntary commitment statute in Pennsylvania.

111. Hiday, *supra* note 69, at 166-67.

commitment. The staff at John Umstead Hospital and each mental health center as well as the legal personnel involved in the process were questioned by mail as to their impressions of outpatient commitment, its effectiveness, and whether they had perceived any changes as a result of the statutes.

There were thirty-eight outpatient commitments in the period before October 1, 1979, and twenty-nine after, representing 4.7 percent of all commitments in the prior period and 3.1 percent of commitments after. Two of the inpatient records in the before period were unavailable for review, and one in the after period, leaving a total of thirty-six records before and twenty-eight after. Of these records, information was obtained from the mental health centers for twenty-five respondents before October 1, 1979 and twenty-four respondents after.

There were some differences noted between the two periods. (1) John Umstead Hospital staff had recommended outpatient commitment for 44 percent of committed respondents who were in fact committed to outpatient treatment before October 1, 1979, and for 77 percent of the respondents committed afterward. (2) The mental health centers' participation in the decision to recommend outpatient commitment, as required by the statutes,¹¹² rose from only 13 percent of cases before to 17 percent afterward. (3) Notification to the mental health centers that a respondent had been committed to them for treatment, according to the mental health center records, increased from 54 percent to 75 percent.¹¹³ (4) If respondents did not comply with the provisions of the treatment plan, there was no action taken by any of the mental health centers before the changes, as compared to action taken in 62 percent of cases after the 1979 revisions. (5) No respondents committed to outpatient treatment returned to the hospital during the period of outpatient commitment before the changes, despite the fact that 38 percent did not come to the clinic as prescribed by the court; after the changes, nine respondents (32 percent of the sample) returned to the hospital, six as a direct result of mental health center action under the new statute.

On the other hand, mental health center participation in treatment plan-

112. This participation by the mental health centers is implicitly required by N.C. Gen. Stat. § 122-58.8(b) (as revised), which states, "The court shall make findings of facts as to the availability and appropriateness of available outpatient treatment before ordering outpatient treatment." Such findings are not possible for a judge to make without involving the clinical staff at the facility to which commitment is contemplated. In addition, the treatment plan required by N.C. Gen. Stat. § 122-58.8(c) cannot be prepared adequately without the participation of the staff of the outpatient facility that would provide the treatment. These provisions were spelled out by the task force and mental health study commission in response to requests from mental health centers to have this input.

113. The increase in notification is related to statutory changes in several ways. (1) The requirement, discussed previously, that mental health centers be involved in the very decision to commit to outpatient treatment obviously involves informing them. See generally notes 59-60 and accompanying text *supra*. (2) The advent of the AAG now provides a specific individual to whom the responsibility has been given to provide information to mental health centers (and our questionnaires indicate that the AAG is the major source of information to mental health centers).

In addition, the statutes prior to 1979 had no explicit requirement for notification to the clinics. N.C. Gen. Stat. § 122-58.8(b) (Supp. 1981) (as revised) states, "If the court orders outpatient treatment a copy of the court order will be sent to the outpatient treatment facility to which the respondent was committed."

ning prior to the court hearing remained infrequent during both periods (13 percent before versus 17 percent afterward). Clinics reported that committed respondents were presented at the clinic within two weeks of their commitment in 62 percent of cases during both periods; the number of respondents remaining in treatment for the duration of the commitment period, including patients whom the clinics felt did not need the full commitment period, actually dropped from 80 percent to 53 percent. The mental health center therapists rated the outpatient commitment as effective in 52 percent of the cases before the new laws, but in only 43 percent of the cases after the new law went into effect.

Opinion questionnaires were received from twelve psychiatrists at John Umstead Hospital and from twenty-one at mental health centers; from three district court judges and two attorneys who hold the commitment hearings at John Umstead; from two clerks of court and one attorney from the community; from fourteen mental health clinic administrators; and from six nurses and two social workers from the mental health centers.

The overall sample of sixty-three who answered the questionnaires gave the following responses: Fifty-three (84 percent) said that they were aware of the changes in the law at the time they went into effect. When asked about what effects of the changes they perceived, seven (11 percent) said no effect; forty-six (73 percent) said that the changes had a little effect; and five (8 percent) said a significant effect (not all respondents answered all questions). As a result of perceived changes, twenty-five (40 percent) said that outpatient commitment had become more effective; twenty-nine (46 percent) said that there had been no appreciable effect; and three (5 percent) felt that outpatient commitment had become less effective. In general, five (8 percent) felt outpatient commitment to be useful for a significant number of respondents; fifty-six (89 percent) felt it to be useful for a small number of respondents; and two (3 percent) felt outpatient commitment should not be used with any respondents.¹¹⁴ In terms of potential, forty-four (69 percent) felt that outpatient commitment could be made more effective, while thirteen (20 percent) felt that no improvements were possible.

There were differences in response from one profession to another, and between the hospital and mental health center staffs. The legal personnel were much more enthusiastic about the changes, and about outpatient commitment

114. One person, a mental health center psychiatrist, stated that he felt that because involuntary commitment was justified only for those who were actively mentally ill and as a result actively dangerous to themselves or to others, all such patients need hospitalization and by definition cannot be treated successfully as outpatients, even under commitment. This opinion has been echoed by some of the district court judges, who in the past have also been reluctant to order outpatient commitment. Others, including those presently sitting at hearings at John Umstead Hospital, accept the clinical argument that outpatient commitment is less restrictive than inpatient commitment and is justifiable in situations in which only enforced continuation of treatment in the community will prevent a recurrence of the illness and rehospitalization. Those for whom the hospital and mental health center staffs agree that outpatient commitment is indicated are those who have repeatedly responded well to treatment in the hospital (generally including medication) but who repeatedly have failed to continue treatment after discharge and eventually return to the hospital unnecessarily. See also note 58 *supra*.

in general;¹¹⁵ twenty-nine percent felt that the changes had made a significant effect, as compared with 9 percent of clinicians and none of the administrators. Seventy-one percent of the legal personnel felt that outpatient commitment had become more effective because of the statutory changes, and none felt that it had become less useful; only 36 percent of clinicians and 47 percent of administrators felt that outpatient commitment had become more effective and most (58 percent of clinicians and 47 percent of administrators) felt that the changes had made no difference.

The hospital staff was somewhat more aware of the changes in the law than the mental health center staff (94 percent as opposed to 80 percent).¹¹⁶ The hospital staff was also more positive towards outpatient commitment and to the effects of the new statutes; more of the hospital staff felt that further improvements in the process of outpatient commitment were possible.¹¹⁷

115. The judges and attorneys, particularly those who participate in the commitment hearings, were more sensitive to least-restrictive-environment issues than were the clinicians; they were therefore more favorable to outpatient commitment. In addition, their greater involvement in the process after the statutory changes and their lack of feedback concerning the actual results of the court-ordered commitments apparently colored their impressions more favorably than those of the clinicians who actually worked with the patients committed by the court.

116. Some of the differences in awareness may have occurred because one-third of the community participants had not been working in the public mental health system at the time of the statutory changes. In addition, none of the mental health staffs had access to full-time attorneys to inform them of the changes. Efforts were made by the hospitals to inform the centers, but these efforts were of necessity carried out with the center leaders and were not always passed on to the full staff, particularly in light of the relatively high staff turnover experienced by mental health centers in the past few years.

117. There were a number of comments and suggestions made by those responding. The most frequent were suggestions made by mental health center personnel that there be more liaison between the centers and the hospitals before outpatient commitment is ordered, more communication between the centers and the court system when outpatient commitment is ordered, and stricter enforcement of the re-hospitalization provisions if patients do not comply with their treatment plans.

The first suggestion reflects that the mental health centers reported participating in the decision to order outpatient commitment in only 10% of cases (4% before and 17% after the changes) and helped to formulate the treatment plan in only 14% of cases (13% before and 17% after). The second suggestion illustrates the level of familiarity with the statutes at the centers; after the changes there were positive results (the patient either returned to the center for treatment or was re-hospitalized) in 75% of the cases in which the center took some action. There were positive results in every case in which the Associate Attorney General at John Umstead Hospital was contacted.

Another suggestion was that the maximum period of 90 days is insufficient to establish a patient in outpatient treatment and that there should be provisions for extension of the outpatient commitment, as exist for inpatient commitment. See N.C. Gen. Stat. § 122-58.11(a) to -11(e) (1981). N.C. Gen. Stat. § 122-58.11(f) currently states, "There are no rehearings for outpatients," thus effectively preventing such an extension. The Division of Mental Health Task Force discussed recommending the provision of rehearings for outpatients, but the attorneys on the task force spoke forcefully against it, and it was dropped.

Other participants from mental health centers urged provisions for initial commitments to mental health centers rather than mandatory inpatient treatment prior to the district court hearing for all respondents, as now required by N.C. Gen. Stat. § 122-58.4(c). This proposal also was discussed by the task force and rejected because of resistance from the attorneys, who felt that the legislature would not accept the concept of mandatory community treatment for persons not sufficiently ill to require at least a brief period of hospitalization prior to community treatment.

There were several criticisms of inappropriate court-ordered outpatient commitments. Examples included patients who clearly were not clinically able to be treated as outpatients and for whom the hospital staff had strongly recommended inpatient treatment; alcoholics committed to mental health centers instead of alcohol treatment facilities in the same community; and patients

Overall, the statutory changes did not seem to have made a significant difference in the use of outpatient commitment. More of the outpatient commitments made after October 1, 1979 followed the procedures as recommended by the Division of Mental Health Task Force to the Mental Health Study Commission, who in turn recommended the procedures to the North Carolina General Assembly, which ratified them; however, there was only one case out of the thirty-five respondents committed to outpatient treatment in the six-month period following the statutory changes that satisfied all the required statutory provisions.¹¹⁸

who were not residents of the counties to whose mental health centers they were committed, who frequently were transient persons considered by the court to be "residents" of the county they happened to be in when the commitment was initiated. There were also complaints that patients were not being told what outpatient commitment meant. This situation occurred in cases in which outpatient commitment had not been recommended by the hospital staff but had been ordered by the judge. In these cases, the patients often left the hospital before the hospital staff knew that they had been released from involuntary hospitalization or had time to explain anything to the patient, including making the necessary contact with the center and providing medications to the patient to last until he could set up an appointment at the center.

All of these criticisms stem from cases in which outpatient commitment had not been recommended by the hospital or mental health center staff but had been ordered by the judge despite the provisions of N.C. Gen. Stat. § 122-58.8(b), which states that "[t]he court shall make findings of facts as to the availability and appropriateness of available outpatient treatment."

Another difficulty with the appropriate use of outpatient commitment is that many respondents have their court hearings as early as three days after admission. In such cases, there is seldom sufficient time for the mutual planning between the mental health center and the hospital staff to prepare an adequate treatment plan. It is often impossible to learn enough about a patient's condition in such a short period of time to decide what is appropriate treatment. N.C. Gen. Stat. § 122-58.8(b) provides for a continuance of seven days at the request of either Special Counsel or Associate Attorney General to allow time for this planning, although this provision was seldom used during the study period.

118. In only one case of outpatient commitment during the six-month period following implementation of the new statutes did a patient have presented at the district court hearing a treatment plan jointly agreed upon by the hospital staff and the mental health center. The usual scenario, so far as the Associate Attorney General and the hospital staff were concerned, was one in which the court ordered outpatient commitment unexpectedly. The Associate Attorney General then would hurriedly try to contact the patient's attending physician to draw up a treatment plan for the record. If the physician could not be found in time or, as frequently happened when the physician felt strongly that outpatient treatment was contraindicated, refused to draw up a plan for what he felt was inappropriate treatment, no plan was entered into the record. As a result, if the patient failed to comply with the commitment and was returned to the hospital, he was automatically released at the supplemental hearing required by N.C. Gen. Stat. § 122-58.8(c) because there was no record of the treatment plan that he was accused of violating.

Perhaps for reasons similar to these, outpatient commitment has received little attention in the legal literature. A few other states have made provisions for outpatient commitment in their statutes, as listed in *The Mentally Disabled and the Law*, supra note 33. Another commentator argued that if least restrictive alternatives to inpatient commitment were available, the state could fulfill more effectively its *parens patriae* obligations with fewer restrictions on patients. Bleicher, *Compulsory Community Care for the Mentally Ill*, 16 *Clev.-Mar. L. Rev.* 95, 105 (1967). But she also noted that many community mental health centers resist treating committed patients. *Id.* See also Cyr, supra note 87, at 114; Ozarin & Brown, *New Directions in Community Mental Health Programs*, 35 *Am. J. Orthopsychiatry* 13 (1965); Special Project, supra note 87, at 1284.

Most reviews of civil commitment procedures do not even discuss outpatient commitment, including Andalman & Chambers, supra note 6; Gupta, supra note 31; Ross, supra note 6; Wenger & Fletcher, supra note 31; Wexler & Scovill, supra note 6. Others mention only voluntary care in the community as a preferable alternative to commitment. See Caldwell, supra note 9, at 530; Cohen, supra note 6, at 452; Dix, supra note 11, at 984; Ellwanger, supra note 11, at 531; Johnson, supra note 6, at 526; Kirkpatrick, supra note 87, at 252; Zander, supra note 9, at 549. Two articles mention outpatient commitment favorably as a less restrictive alternative to inpatient commitment. See Projects, supra note 6, at 867; Developments, supra note 12, at 1250.

VI. EMERGENCY PROCEDURES FOR INVOLUNTARY HOSPITALIZATION

It has been said frequently that psychiatrists possess no special expertise either in recognizing the presence of mental illness severe enough to warrant involuntary commitment¹¹⁹ or in predicting dangerousness in the future.¹²⁰ Some have criticized the adequacy of evidence given by psychiatrists in commitment hearings and have suggested that other professionals, such as law enforcement officers, would be better able to perform those functions.¹²¹ We have compared the level of evidence given on emergency petitions by trained law enforcement officers with the evidence given by community physicians on their commitment evaluation forms. The evidentiary requirements are the same, except that the emergency petitions must also include evidence that the delay for a physician's examination would present a significant risk of damage to person or property and evidence of violent behavior.¹²²

The names of all adult respondents brought to John Umstead Hospital under emergency hospitalization conditions and who had initial commitment hearings during the periods March 1, 1979 through August 31, 1979 and October 1, 1979 through March 31, 1980 were obtained from the log kept in the Admissions Office (the index admission). The medical records of these patients were requested from the records library.

Each available record was investigated to determine the following data: age, gender and race of the respondent; number of admissions before and after the index admission; duration of the index admission; type of admission—mentally ill or inebriate; identity of petitioner's profession (police or sheriff); physician recommendations upon admission and just prior to the court hearing; and disposition of the respondent's case at the hearing. In addition, the statements on the petitions were examined to determine whether the information required by the North Carolina statutes was present.

119. Thomas Szasz takes the position that mental illness is a label assigned by psychiatrists to behavior that appears unacceptable and is not illness in the medical sense; he therefore argues against the use of psychiatric testimony in civil commitment, to which he is also completely opposed. T. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (1961). S. Morse, in *Crazy Behavior, Morals and Science: An Analysis of Mental Health Law*, 51 S. Cal. L. Rev. 530, 560 (1978), argues that the determination of mental illness for legal purposes is a social and moral issue, not a scientific or medical one, and that the participation of psychiatrists and other "experts" should be severely limited. Ennis and Litwack argue at some length that psychiatric diagnoses, usually the bases for testimony concerning the presence of mental illness, are neither reliable nor accurate. Ennis & Litwack, *supra* note 16, at 695. Livermore, Malmquist and Meehl conclude that even the official diagnostic manuals of the American Psychiatric Association are unavoidably ambiguous and thereby allow a diagnostician to "shoehorn" into the "mentally diseased" class almost any person he wishes. Livermore, Malmquist & Meehl, *supra* note 13, at 80. See also Bassiouni, *supra* note 7, at 295; Cohen, *supra* note 6, at 436; Ross, *supra* note 6, at 950; Spitzer & Fleiss, *A Re-analysis of the Reliability of Psychiatric Diagnosis*, 125 *Brit. J. Psychiatry* 341 (1974).

120. See note 24 *supra*.

121. Monahan argues that since prediction of any behavior is more accurate if done in the setting in which the behavior is predicted to occur, "there is no *a priori* reason to assume that psychiatrists or psychologists would be any better at prediction in emergency situations than other observers or participants (e.g., a police officer or a potential victim)." Monahan, *supra* note 24, at 200. See also Dershowitz, *supra* note 24, at 47; Ennis & Litwack, *supra* note 10, at 735.

122. N.C. Gen. Stat. § 122-58.18 (1981).

Data on the number of admissions to the hospital during those periods, broken down by county of referral, and data on length of stay for all patients during the study periods were obtained from the Division of Mental Health, Mental Retardation, and Substance Abuse records. Data on the results of all commitment hearings during the period of study have been discussed earlier in this Article.¹²³

In addition, the authors examined the records of 200 respondents admitted involuntarily over a three-month period (April-June 1981) to the acute adult admissions unit at John Umstead Hospital.¹²⁴ These records represented eighty percent of all patients so admitted to the unit during the time period; the remaining records were not reviewed because of time and logistical considerations and are not expected to differ significantly from those reviewed.¹²⁵

Seventy-seven respondents were brought to John Umstead Hospital under emergency petitions during the period from March 1979 through March 1980 (the period from which the previous data on commitment were obtained). Five of these records were at other state facilities at the time of the study and therefore unavailable, leaving seventy-two records for analysis. There were no significant differences between the patient populations or findings in the two six-month periods of study, so the data were combined for this analysis. Respondents committed under emergency provisions represented 4.4 percent of all persons committed during the periods.¹²⁶

In evaluating the adequacy of the evidence on the emergency hospitalization petitions executed by law enforcement officers, we determined whether, in our opinion, adequate evidence of mental illness as required by statute was present. We also determined whether the special provisions for emergency commitment requiring a showing that delay for examination by a physician would endanger life or property were adequately documented.¹²⁷

The results were that only 29 percent of the petitions had even minimally

123. See Tables 1-3, Appendix *infra* and text accompanying notes 77-111 *supra*.

124. This unit receives all patients from age 18 through age 64 having primary psychiatric, as opposed to alcohol or drug, problems. It receives approximately 2000 admissions per year, 65% of which are involuntary.

125. There is no reason to believe that the sample is unrepresentative of the population at large. This sample, unlike the emergency hospitalization sample, did not include inebriates or patients over age 65; but the adequacy of petitions in the emergency hospitalizations population did not differ between mental patients and inebriates, or between patients over and under age 65. Thus, there is no reason to suppose that the use of data from mental patients alone in the sample of physician recommendations would introduce any deviation in the results.

126. One thousand seven-hundred thirty-five involuntarily committed adult patients had initial hearings at John Umstead Hospital during the 12-month study period. There were 43 emergency hospitalization patients whose hearings were held between March 1 and August 31, 1979 (4.9% of all initial hearings), and 35 emergency hospitalization hearings between October 1, 1979, and March 31, 1980 (3.5% of all initial hearings during that period). Mental patients hospitalized under emergency hospitalization represented 5.6% of all hearings for mental patients before and 5.5% after October 1, 1979. Inebriates declined from 3.9% of all committed inebriates before to 1.5% after October 1, 1979. There were no significant differences in the results between the two periods, so the data were combined for analysis.

127. The following examples are typical of the statements found in the petitions in this study:

1. "Respondent is in DTs, seeing things on the walls, seeing people being killed; can't an-

adequate evidence of both mental illness and risk to property or person from delay. Twenty-one percent had insufficient evidence of mental illness, 42 percent had insufficient evidence of risk from delay and 8 percent had sufficient evidence of neither criterion. The comparable figures from physicians' evaluations reveal that 61 percent of nonpsychiatric physicians gave sufficient evidence of both mental illness and dangerousness to self and others; thirty-three percent had insufficient evidence of mental illness and 6 percent had insufficient evidence of dangerousness. For psychiatrists (who performed 82 percent of the community evaluations during the study period) the adequacy was even higher; ninety-five percent of their evaluations gave sufficient evidence of both criteria, with only 2 percent having insufficient evidence of mental illness and 2 percent insufficient evidence of dangerousness.¹²⁸

Another interesting point from the study of the emergency procedures is the frequency of its use in different counties. John Umstead Hospital's catchment area includes six counties considered to be urban (greater than 35,000 population) and ten rural counties (35,000 or fewer). Emergency hospitalization respondents were admitted during the study from all urban counties and eight of the ten rural counties. In addition, during the study periods the sixteen counties were divided into two catchment areas, one relatively close to the hospital (ten counties, three urban and seven rural; all provided respondents during the study) and one farther (six counties, three rural and three urban; two of the rural counties were not represented by emergency hospitalization respondents during the study periods).

Table 4 demonstrates that while all involuntary admissions per capita during the study periods were slightly higher from the rural counties, the emergency hospitalization admissions from rural areas were seven to nine

swer simple questions." (Evidence of inebriety and mental illness, but no evidence of dangerousness or any risk from delay.)

2. "Respondent beats his head against the wall of his cell, tore up his mattress, tore out the plumbing, flooding the cell, tried to set a fire." (Evidence that delay might lead to further personal or property damage, but no evidence of mental illness.)

3. "Respondent passed out and hurt himself; he lives alone and there is no one to care for him." (No evidence of either mental illness or of any risk to person or property from a delay.)

4. "Respondent is violent and talking all kinds of nonsense; she struck a deputy by kicking him in the leg and striking him in the face with her fist. Will not take advice." (Minimal but sufficient evidence of mental illness; clear evidence of risk of delay.)

128. The demonstration that physicians are considerably more complete in their evaluations in providing the required evidence for mental illness and dangerousness (no matter what one thinks about the reliability or validity of that evidence) than are police or sheriffs is in marked contrast to earlier studies that demonstrated a lack of evidence from physicians. See Hiday & Markell, *Components of Dangerousness: Legal Standards in Civil Commitment*, *Int'l J.L. & Psychiatry* (in press, 1982); Stier & Stoebe, *Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation*, 64 *Iowa L. Rev.* 1284 (1979); Warren, *supra* note 23, at 642. But see Monahan, Caldeira & Friedlander, *Police and the Mentally Ill: A Comparison of Committed and Arrested Persons*, 2 *Int'l J.L. & Psychiatry* 509 (1979), based on interviews with 100 police officers—50 just after they had instituted emergency hospitalization procedures and 50 just after they had made arrests. The officers reported evidence of mental illness and dangerousness in all committed patients. This was done not under actual working conditions, however, but in an artificial interview situation. In contrast, our data compare the actual written evaluations presented to the court from physicians and law enforcement officers.

times greater than from urban areas. In addition, while the total involuntary admissions per capita from the closer counties were some five times greater than from the farther counties, the ratio for emergency hospitalization respondents was twenty to twenty-five times greater from the closer counties. There were no significant differences between the two study periods.

As has been suggested in the past,¹²⁹ areas without readily available (or cooperating) physicians tend to overutilize emergency commitment procedures in order to avoid the usual requirement for physician evaluations prior to admission, rather than use emergency procedures only for respondents presenting special risks. Our study would support these views.

VII. CONCLUSIONS

No matter how objective an attorney or a physician attempts to be, he will bring to his job his own beliefs and will be influenced by the society and culture in which he lives.¹³⁰ The past two decades have been characterized by an explosion in the recognition of the rights of individuals as opposed to those rights of society in general.¹³¹ This trend has resulted in the application to the

129. Hiday, *supra* note 89, at 656 n.7; Matthews, Observations on Police Policy and Procedures for Emergency Detention of the Mentally Ill, 61 J. Crim. L., Criminology & Police Sci. 283, 295 (1970); Pfrender, Probate Court Attitudes Towards Involuntary Hospitalization: A Field Study, 5 J. Fam. L. 139, 145 (1965). In one rural county in North Carolina, not in our hospital's catchment area, no physician in the county would evaluate patients for commitment after the statutory changes in 1977 that created the office of Special Counsel to represent respondents. The community physicians who evaluated patients were regularly subpoenaed to commitment hearings, causing them to lose at least half a day's work without compensation. None was a psychiatrist, none had any interest in participating in the commitment process, and none was under any obligation to do so. As a result, for a time virtually all commitments in that county were under emergency hospitalization provisions. Nearly 90% of those patients were released at their subsequent district court hearings upon objections by Special Counsel to the improper use of emergency hospitalization procedures. This situation contrasts with the finding of Brakel, South and Matthews that the use of emergency hospitalization declined because of physician resistance to the procedures. J. Brakel, T. South & A. Matthews, Diversion from the Criminal Process in the Rural Community 70 (1968).

130. See Andalman & Chambers, *supra* note 6, at 54; Ross, *supra* note 6, at 958; Zander, *supra* note 9 (generally noting that the differences in procedures in two counties in Wisconsin were the result only of differences in the attitudes of the judges). See also Maisel, *supra* note 10, at 358.

The legal profession in general has seen little inconsistency in attacking the arbitrary power of the psychiatrist when the judge agrees with him, while applauding the attorney when the judge agrees with him. This attitude reveals the underlying bias against the whole concept of involuntary civil commitment by many legal authors; this bias should be taken into consideration when evaluating their arguments. This bias is explicit in Andalman & Chambers, *supra* note 6, at 49; Livermore, Malmquist & Meehl, *supra* note 13, at 75-76; Recent Decisions, *supra* note 9, at 196.

131. The Supreme Court under Chief Justice Warren was perhaps the most visible (and influential) factor in this process; many of the Court's landmark decisions in the fields of education and criminal law later influenced the mental health law field. See, e.g., *Miranda v. Arizona*, 384 U.S. 486 (1966); *Escobedo v. Illinois*, 376 U.S. 496 (1964); *Gideon v. Wainwright*, 372 U.S. 335 (1963); *Brown v. Board of Educ.*, 349 U.S. 294 (1954). The right-to-counsel provisions of *Gideon* and *Escobedo* have been translated into a right to counsel for committed persons. The "*Miranda* warning" was an integral part of the decision in *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972) and of the recent decision in *Estelle v. Smith*, 451 U.S. 454 (1981), in which the Supreme Court held that a defendant who is to be examined by a psychiatrist to determine aggravating or mitigating circumstances as well as sanity and competence to proceed to trial, must be informed of the full purpose of the examination, must be able to consult with counsel before undergoing the evaluation and must have the right to refuse the evaluation. In the opinion, Chief Justice Burger

civil commitment process of procedures designed to protect individuals accused of crimes and in a decrease in the percentage of commitments of those brought into the process.

The more recent upsurge in interest in "law and order" and the protection of society has led to a retrenchment of the move toward greater rights for mental patients¹³² and to increased pressure from members of the public to protect them from exposure to mental patients as well as from criminals.¹³³ The dissolution of extended family units and the urbanization of more and more of our society have destroyed the safe habitats for mentally disordered persons just as they have for many species of animals. Unlike endangered species, however, the numbers of mental patients may well be on the rise, with the increased stresses in present society¹³⁴ and the increased transmission of

quoted the *Miranda* decision as the basis for the current decision. 451 U.S. at 446 (quoting *Miranda*, 384 U.S. at 444).

132. At the judicial level, the most striking change has been in the Supreme Court. The change from judicial activism in defense of individual civil liberties by the Warren Court to a more strict constructionist view by the Burger Court is clearly reflected in decisions such as *O'Connor v. Donaldson*, 423 U.S. 563 (1975), in which the Court refused to decide the larger issue of a constitutional right to treatment. See also *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1 (1981) (the Court took a narrow view of Congress' intentions in the Developmental Disabilities Act, 42 U.S.C. § 6001 (1976 & Supp. III 1979), and held that the Act did not require the closing of a substandard facility for the mentally retarded, as the lower courts had ordered); *Parham v. J.R.*, 442 U.S. 584 (1979) (the Court held that judicial review was not necessary to protect the rights of a minor committed for psychiatric treatment by his parent or guardian; *Addington v. Texas*, 441 U.S. 418 (1979), in which the Court chose to adopt a standard of proof ("clear and convincing evidence") that was less than the appellant's requested "beyond a reasonable doubt" standard). For a review of these cases, see D. Wechsler, *Mental Health Law—Major Issues* (1981).

133. See Perr, *Hospitalization and History: Philosophy Drives Psychiatry Down a Winding Path*, *Legal Aspects Med. Prac.*, May 1979, at 44, 47 (Psychiatry ed.), describing a counter-revolution occurring due to increased violence and the "dumping" of mental patients on communities as a result of deinstitutionalization and stricter commitment procedures. See also Shah, *supra* note 11, at 709; Steadman, *supra* note 10, at 270. Steadman points out that when persons who had committed crimes were released from a hospital for the criminally insane and committed further crimes, the news media referred to them as "ex-mental patients," not as "ex-criminals." *Id.* at 270 n.8. The combination of mental illness and criminal behavior seems to raise far more fears than the statistics for such persons would justify. In many persons' minds, every former mental patient is a potential violent criminal. See Bazelon, *The Right to Treatment: The Court's Role*, 20 *Hosp. & Community Psychiatry* 129, 131 (1969).

134. See Slovenko & Luby, *On the Emancipation of Mental Patients*, 3 *J. Psychiatry & L.* 191, 194 (1975). The effects of crowding on experimental animals has been well described. See generally Barnett, *Physiological Effects of "Social Stress" in Wild Rats: The Adrenal Cortex*, 3 *J. Psychosomatic Research* 1 (1958). Similar forces are creating comparable stresses in contemporary American society. Dr. Hans Lowenbach, Professor Emeritus of Psychiatry at Duke University, describes the rarity of diagnoses of schizophrenia in North Carolina prior to World War II, and the dramatic increase in reports in 1941 when the draft removed many young schizophrenic men from their protective rural surroundings and exposed them to conditions with which they could not cope, resulting in rapid deterioration of their mental health. Personal Communication from Dr. Lowenbach to authors, 1974. For a discussion of the effects of stress upon severe depression and other mood disorders, see Arieti, *Affective Disorders: Manic—Depressive Psychosis and Psychotic Depression*, in *American Handbook of Psychiatry* 469 (S. Arieti & E. Brady 2d ed. 1974). A similar discussion of the effects on schizophrenic illnesses can be found in Arieti, *Schizophrenia, the Psychodynamic Mechanisms and the Psychostructural Forms*, in 3 *American Handbook of Psychiatry*, *supra*, at 568. See also Miller, *Psychological and Psychiatric Aspects of Population Problems*, in 6 *American Handbook of Psychiatry* 977 (D. Hamburg & K. Brodie 2d ed. 1975) for the effects of population density on the levels of mental illness. Schmidt, *Density, Health and Social Disorganization*, 32 *Am. Inst. Plan.* 38 (1966), presents a general discussion concerning the effect of the dissolution of extended family support systems and social isolation

genetically-predisposed illnesses, because today more victims of such illnesses often are able to have children.¹³⁵ More nonaffected people are being exposed to mentally disordered behavior than previously, and they are demanding that the situation be carefully monitored.

The impact of lay witnesses on the results of commitment hearings in North Carolina as shown in our study indicates the direction in which society is moving. The deinstitutionalization movement has slowed considerably, having run into the stumbling blocks of decreased public willingness to fund community programs¹³⁶ and widespread resistance to the relocation of mental patients in communities as part of the normalization of their lives.¹³⁷ Even when hospital staffs attempt to encourage community treatment through the use of outpatient commitments for patients who otherwise would have to be

upon the mental health of individuals. See also Cardoza, Ackerly & Leighton, *Improving Mental Health Through Community Action*, 11 *Community Mental Health J.* 215 (1975), for a review of literature related to the impact of social stress on mental illness.

135. Baldessarini, *Schizophrenia*, 297 *New Eng. J. Med.* 989 (1977); Fieve, Mendlewicz & Fleiss, *Manic-Depressive Illness: Linkage with the Xg Blood Group*, 130 *Am. J. Psychiatry* 1355 (1973); Gershon, Dunner & Goodwin, *Toward a Biology of Affective Disorders: Genetic Contributions*, 25 *Archives Gen. Psychiatry* 1, 1-4 (1971); Kety, *From Rationalization to Reason*, 131 *Am. J. Psychiatry* 957 (1974); Mendels, *Biological Aspects of Affective Illness*, in 3 *American Handbook of Psychiatry*, supra, at 491; Murphy, Goodwin & Bunney, *The Psychobiology of Mania*, in 4 *American Handbook of Psychiatry*, supra note 133, at 502; Pollin, *The Pathogenesis of Schizophrenia*, 27 *Archives Gen. Psychiatry* 29, 31-32 (1972); Rosenthal, *The Genetics of Schizophrenia*, in 3 *American Handbook of Psychiatry*, supra, at 588; *Genetics Alone Explain Similar Traits in Twins Raised Apart*, *Clinical Psychiatry News*, Oct. 1980, at 1. See also Arnhoff, *Social Consequences of Policy Toward Mental Illness*, 188 *Science* 1277 (1975).

136. The wave of enthusiasm for community treatment that followed President Kennedy's call for a "bold new approach" to mental health, see Kennedy, *Special Message to Congress on Mental Illness and Mental Retardation*, *Pub. Papers* 126-27 (Feb. 5, 1963), and the originally lavish funding for the new community mental health centers have virtually evaporated in the wake of disillusionment over the relative ineffectiveness, measured against what can now be seen to have been unreasonable expectations, of community treatment programs. Even with the trend toward directing the focus of community mental health centers to the severely and chronically mentally ill (who are the majority of the population at risk for involuntary commitment) in the *Mental Health Systems Act*, *Pub. L. No. 96-398*, § 201, 94 *Stat.* 1564, 1571-73 (1980), the current cutbacks by the Reagan administration are another indication of society's growing unwillingness to spend the amount necessary to provide effective community alternatives to involuntary hospitalization. In addition, the ever stricter requirements from accrediting agencies such as the *Joint Commission on Accreditation of Hospitals* and the *National Institute of Mental Health* (which surveys for Medicare accreditation) have caused state hospital costs to rise dramatically, thus preventing diversion of the predicted amount of available money into community programs.

The literature on deinstitutionalization is voluminous. Perhaps the most reasoned writer on the subject is the sociologist Leona Bachrach. For a thorough, current survey of the problems of providing effective community-based services for the chronically mentally ill, see Bachrach, *Concepts and Issues in Deinstitutionalization*, in *The Chronic Psychiatric Patient in the Community: Principles of Treatment* (I. Barofsky & R. Budson eds. 1981).

137. The strong, sometimes even violent reactions of communities and neighborhoods to the advent of former mental patients—the "little Agnews," a concentration of deinstitutionalized patients that grew up around the University of California at San Jose campus after the closing of Agnews State Hospital; the problems of Long Beach, New York (presented on several national television programs); and the creation of psychiatric ghettos in the Bowery in lower Manhattan—have received wide media attention but are just the tip of the iceberg. See Aviram & Segal, supra note 28, at 129. Most of the studies have utilized abstract questionnaires, which generally fail to estimate accurately the responses of neighborhood residents to actual attempts to establish facilities for former hospital patients.

Cities respond to the "threat" of mental patients with zoning laws and other restrictions designed to prevent the advent of group homes and other similar facilities. *Id.* at 129. See also Chase, supra note 23, at 14; Kirk & Thierren, *Community Mental Health Myths and the Fate of*

hospitalized, obstacles in the form of judicial noncompliance with the spirit and letter of the legislation and community mental health center resistance to outpatient treatment prevent its effective utilization. As hospital populations have declined, jail and prison populations have risen,¹³⁸ another indication of community resistance to normalization for mental patients.

The use of emergency commitment by law enforcement officers and magistrates to bypass statutory safeguards in the form of a second independent medical evaluation is another example of society's desire to remove unwanted persons from its neighborhoods by whatever means necessary. It would seem that we have not come far from the age-old practice of abandoning mentally

Former Hospitalized Patients, 38 *Psychiatry* 213 (1975); Talbott, *Deinstitutionalization: Avoiding the Disasters of the Past*, 30 *Hosp. & Community Psychiatry* 623 (1979).

Another method for discouraging the community relocation of mental patients is to sue anyone who can be held responsible for the consequences of their behavior. In *Sampson v. Saginaw Prof. Bldg., Inc.*, 393 Mich. 393, 224 N.W.2d 843 (1975), the owner of an office building containing a mental clinic was held liable for injuries sustained by a person attacked by a patient in the building.

138. When hospitals close and stricter commitment laws prevent or limit hospitalization, many patients who cannot control their behavior are forced into the community. Without the hospital as an alternative, many commit crimes (usually minor), and community intolerance ultimately forces the police to place them in jail. See Abramson, *supra* note 25, at 103; Slovenko & Luby, *supra* note 134, at 201. Stelovich, in *From the Hospital to the Prison: A Step Forward in Deinstitutionalization?*, 30 *Hosp. & Community Psychiatry* 618, 618 (1979), states that the number of patients transferred directly from mental hospitals to prisons has tripled as Massachusetts has closed some of its mental hospitals.

In contrast to earlier studies that demonstrated that mental patients as a group had lower arrest rates than the general population, see Pollack, *Is the Paroled Patient a Menace to the Community?*, 12 *Psychiatric Q.* 236 (1938); Rapoport & Lassen, *Dangerousness and Arrest Rates: Comparison of Discharged Patients and the General Population*, 121 *Am. J. Psychiatry* 776 (1965), more recent studies have revealed that mental patients now seem to have higher arrest rates than nonpatients. See Sosowsky, *Crime and Violence Among Mental Patients Reconsidered in View of the New Legal Relationship Between the State and the Mentally Ill*, 135 *Am. J. Psychiatry* 33 (1978); Sosowsky, *Exploring the Increased Arrest Rate Among Mental Patients: A Cautionary Note*, 137 *Am. J. Psychiatry* 1602 (1980). See also Bonovitz & Guy, *Impact of Restrictive Civil Commitment Procedures on a Prison Psychiatric Service*, 136 *Am. J. Psychiatry* 1045 (1979); Durbin, Pasewark & Albers, *Criminality and Mental Illness: A Study of Arrest Rates in a Rural State*, 134 *Am. J. Psychiatry* 80 (1977); Grunberg, Klinger & Grumet, *Homicide and the Deinstitutionalization of the Mentally Ill*, 134 *Am. J. Psychiatry* 685 (1977); Rabkin, *Criminal Behavior of Discharged Mental Patients: A Critical Appraisal of the Research*, 86 *Psychology Bull.* 1 (1979); Steadman, Coccozza & Melick, *Explaining the Increased Arrest Rate Among Mental Patients: The Changing Clientele of State Hospitals*, 135 *Am. J. Psychiatry* 816 (1978); Whitmer, *From Hospitals to Jails: The Fate of California's Deinstitutionalized Mentally Ill*, 50 *Am. J. Orthopsychiatry* 65 (1980); Zitrin, Hardesty & Burdock, *Crime and Violence Among Mental Patients*, 133 *Am. J. Psychiatry* 142 (1976).

Sosowsky found that the number of mental patients with previous arrest records had increased. Sosowsky, *Exploring the Increased Arrest Rate Among Mental Patients*, *supra*. His findings were bolstered by Steadman, Coccozza & Melich, *supra*. Sosowsky also found, however, that those without previous arrest records had a higher incidence of arrests after discharge than the general population; in his study, 24% were arrested during the 6.5 years of the study period, and of these, 53% were arrested within 19 months after discharge. He postulates that the pressures to deinstitutionalize in California caused the discharge of a number of patients unprepared for successful community life, and attributes the greater percentage of inpatients with previous arrests (53%) to stricter commitment criteria emphasizing dangerousness. Sosowsky, *Exploring the Increased Arrest Rate Among Mental Patients*, *supra*, at 160. Another possible reason for the increased percentage of patients with prior criminal records is that the less severely ill patients are less frequently treated in state hospitals now. See note 140 *infra*. Thus, even without an absolute increase in the numbers of patients with criminal records, the decrease in the number without such records being hospitalized would lead to overrepresentation of the criminally disturbed.

disordered persons in other communities to avoid responsibility for their care.¹³⁹

Clinicians have argued for years that the real choice for patients with severe mental illnesses (who make up a majority of state mental hospital populations)¹⁴⁰ is not freedom versus incarceration in a mental hospital. Rather, the choice is between a chronic loss of internal freedom due to the illness itself versus periods of hospitalization and treatment followed by enhanced ability to utilize the external freedom after discharge.¹⁴¹ Now the choice for the men-

139. Deutsch, *supra* note 6, at 124; Weihofen & Overholser, *Commitment of the Mentally Ill*, 24 *Tex. L. Rev.* 307, 309 (1946).

140. Eichman & Abbott, *Evaluation of Psychiatric Hospital Effectiveness as Judged by Family Members* (unpublished paper presented June 26, 1981, at Grand Rounds, John Umstead Hospital, Butner, North Carolina (found that 69% of the adult males and 56% of the adult females at the hospital's adult acute unit had been diagnosed as psychotic). See also Herz, *Short-Term Hospitalization and the Medical Model*, 30 *Hosp. & Community Psychiatry* 117, 119 (1979) (found 63% of his patient population to be schizophrenic). Because of the stricter commitment criteria around the country emphasizing dangerousness, the presence of adversarial respondent attorneys in more jurisdictions, the number of community mental health centers that still concentrate their services for the less disturbed, and the pressures on hospitals to decrease their populations, the patients with less severe disorders often are denied admission to the state hospitals. Thus the representation in the hospital population of those with severe and chronic disorders has increased.

141. For the clinical viewpoint of the effects of severe mental illness upon "freedom," see Rachlin, *With Liberty and Psychosis for All*, 48 *Psychiatric Q.* 410 (1974) (points out that "freedom" is a meaningless term without mental health). Reich, in *Care of Chronically Mentally Ill—A National Disgrace*, 130 *Am. J. Psychiatry* 911, 912 (1973), states that the "freedom to be sick, helpless, and isolated is not freedom." Many clinicians feel that seriously ill patients actually experience more true freedom in a hospital, where they are not ostracized and can be helped to control impulses they find unacceptable and to reduce their regression, than in the apparent "freedom" outside a hospital. See Abroms, *Setting Limits*, 19 *Archives Gen. Psychiatry* 113 (1968); Friedman, *Some Problems of Inpatient Management With Borderline Patients*, 126 *Am. J. Psychiatry* 299 (1969); Herz, *Views on the Current Role of Psychiatric Hospitalization*, 23 *Hosp. & Community Psychiatry* 210 (1972); Manasse, *Self-Regard as a Function of Environmental Demands in Chronic Schizophrenia*, 70 *J. Abnormal Psychology* 310 (1965); Michaux, Chelst, Foster & Pruim, *Day and Full-Time Psychiatric Treatment: A Controlled Comparison*, 14 *Current Therapeutic Research* 279 (1972).

Even such widely attacked methods as seclusion and restraint can actually be used therapeutically to increase the true freedom of some patients whose loss of internal controls are more frightening to them than the locked doors and restraints. The authors have treated a number of patients who have asked to be put in seclusions, or even restraints, and others whose illnesses prevented them from asking verbally, but who were able to realize the benefits after recovery. One patient on the ward would become very agitated and begin to tear drapes and shades off the windows, but would calm down immediately after being put in seclusion. After this pattern had occurred several times, we suggested to him that when he felt like attacking the drapes he could tell the ward staff and they would be glad to put him in the quiet room. He gladly accepted the idea, and thereafter asked to be secluded whenever he felt out of control.

Many of the reports of abuses that have led to reforms in mental health practices have come from angry former patients. Nevertheless, there are reports in the literature that the majority of patients feel that hospitalization, even on locked wards, was necessary and beneficial for them. This does not excuse the abuses, but should caution reformers that they run the risk of denying the majority of patients access to effective treatment in order to prevent risks to the minority. See Fischer & Weinstein, *Mental Hospitals, Prestige, and the Image of Enlightenment*, 25 *Archives Gen. Psychiatry* 41 (1971); Miller, *Voluntary "Involuntary" Hospitalization: The Briar Patch Syndrome*, 8 *Bull. Am. Acad. Psychiatry & L.* 305 (1980); Rachlin, *On the Need for a Closed Ward in an Open Hospital: The Psychiatric Intensive-Care Unit*, 24 *Hosp. & Community Psychiatry* 829 (1973); Ryan, *The Therapeutic Value of the Closed Ward*, 134 *J. Nervous & Mental Disease* 256 (1972); Toews, El-Guebaly & Leckie, *Patients' Reactions to Their Commitment*, 26 *Can. J. Psychiatry* 251 (1981).

There is also agreement on some of these points in the legal literature. See Slovenko & Luby, *supra* note 134. The Supreme Court in *O'Connor v. Donaldson*, 422 U.S. 563 (1975), held that a

tally disordered is even narrower; if not treated, the prospect of imprisonment in the penal system is greater than at any time since the days preceding creation of public mental hospitals.¹⁴² The nascent right to treatment, proposed enthusiastically by attorneys and clinicians alike, will scarcely flourish if patients are systematically denied the opportunity to receive that treatment.¹⁴³ The present trends in mental health law still seem to be concentrating on reducing involuntary (or even voluntary) hospitalization.¹⁴⁴ If this trend continues without equal or greater emphasis on efforts to develop realistic treatment alternatives elsewhere, then the very patients that the legal and clinical professions see as their clients will continue to find their choices reduced rather than expanded.

Many authors have criticized clinicians, often accurately, for preempting (usually by default) decisions that rightfully belong to society through its judges, juries and legislatures.¹⁴⁵ We would contend that the same arguments apply to those attorneys and judges¹⁴⁶ who would impose their particular views—concerning where, how and whether mentally disordered persons should be treated—on their clients and on society, without consulting society's wishes. By ignoring the clearly demonstrated intentions of a society not yet ready to accept the mentally disordered into its neighborhoods, the mental

patient may be more dangerous to himself if he is "helpless to avoid the hazards of freedom" than if he is hospitalized against his will. *Id.* at 574 n.9.

142. See note 138 *supra*.

143. Rachlin, Pam & Milton, *supra* note 13, at 191, argue that the right to treatment is more important than the right to refuse treatment. See Rachlin, *supra* note 32, at 99 (arguing that efforts to decrease involuntary hospitalization have also hindered the right to treatment). See also Peele, Chodoff & Taub, *supra* note 30, at 744. Ennis, *supra* note 19, at 4, states that as yet there is no absolute constitutional right to treatment, but many clinicians feel that there should be. There is one case that could be interpreted as finding a right to treatment on constitutional grounds: *Nason v. Superintendent of Bridgewater State Hosp.*, 353 Mass. 604, 612-13, 233 N.E.2d 908, 913 (1968). See also Bassiouni, *supra* note 7, at 292; Katz, *The Right to Treatment—An Enchanting Legal Fiction?*, 36 U. Chi. L. Rev. 755 (1969) (discussing the question of whether a patient can waive his right to treatment). Katz states that "a third objective of the right to treatment is to support and nourish society's humanitarian impulses," and to give heed to the patient's unconscious wishes for help. *Id.* at 763.

Once admitted, few involuntarily committed patients actually refuse treatment despite the legal and clinical furor over the right to refuse treatment. See Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 Am. J. Psychiatry 340 (1980) (a report of a study done in the jurisdiction under the *Rogers v. Okin* decision).

144. Many authors contend that even hospitalizations classified as "voluntary" in the legal sense are in fact coerced, and should be reduced or abolished. See Szasz, *supra* note 13; Gilboy & Schmidt, *supra* note 110, at 452. In North Carolina in the past five years, the percentage of patients admitted to our state hospitals under voluntary status has actually decreased. See Miller, *Beyond the Old State Hospital: New Opportunities Ahead*, 32 Hosp. & Community Psychiatry 27 (1981).

145. See notes 6, 10, 11 & 110 and accompanying text *supra*.

146. Some activist judges have attempted to implement their beliefs by creating new law through their court decisions. The most famous example was Judge Bazelon's creation of the "Durham" Rule (*Durham v. United States*, 214 F.2d 826 (D.C. Cir. 1954)), which established a new standard of insanity for criminal trials: a defendant would be considered insane if his criminal act were the product of a mental illness or defect. Although later modified in *Carter v. United States*, 252 F.2d 608 (D.C. Cir. 1957), and *McDonald v. United States*, 312 F.2d 847 (D.C. Cir. 1962), and finally abandoned in *United States v. Brawner*, 471 F.2d 969 (D.C. Cir. 1972), the Durham Rule gave more discretion to psychiatrists than many had been willing to accept.

health bar is not always acting in the best interests of its clients.¹⁴⁷

147. In the various attacks on psychiatrists for usurping authority by using the medical model of mental illness, there is the assumption, both implicit and occasionally explicit, that decisions to take away someone's external freedom should be made by "society" and not by a professional, paternalistic, "expert" psychiatrist. Just as in the case of Plato's Philosopher King, the problem is deciding who will choose the King. Clinicians, by and large, have chosen themselves, arguing that only they possess the training to recognize mental illness in all of its forms and the knowledge to treat it effectively. (As a matter of interest, the study of Toews, El-Guebaly & Leckie, *supra* note 141, at 253, demonstrates that patients agree that clinicians are in the best position to make decisions on commitment.)

Attorneys have chosen themselves, arguing that only they possess the training and knowledge to understand and represent the law, which is the codified wishes of society. The two professions have a number of basic philosophical differences that continue to make dialogue difficult. The law assumes that all adults are competent in every way until proved otherwise in court, and that each person possesses complete free will and is, therefore, responsible for all of his actions. Attorneys thus dispute the attribution of causation for any behavior to mental illness. See generally Morse, *supra* note 119; Robitscher, *supra* note 14; Szasz, *supra* note 10. Attorneys fond of quoting John Stuart Mill contend that freedom from external restraints is the highest goal; therefore, commitment procedures, like criminal trials, should be set up to err in the direction of release rather than commitment. Thomas Scheff, in *Being Mentally Ill: A Sociological Theory* (1966), calls this favoring Type 2 errors (release of committable patients) over Type 1 errors (committing people who do not meet the criteria). Litwack suggests that psychiatrists are prone to perceive clinical symptoms in ambiguous behavior because they are trained in medical school that it is better to suspect illness and be wrong than to erroneously reject the possibility of illness. Ennis & Litwack, *supra* note 24, at 720. This tendency is reinforced in the civil commitment area, in which the public outcry if a released patient commits a violent act has in the past far outweighed any objections to admission and detention of patients. See Comment, *supra* note 12, at 1554; Lewinson & Ramsay, *supra* note 24, at 179.

Attorneys, on the other hand, hold to the principle that "it is better that ten guilty persons escape than that one innocent suffer." 4 W. Blackstone, *Commentaries* 358.

The law is set up on the basis of dichotomies—guilty/innocent, commit/release, and so forth; however, clinicians deal with gradations along a continuum. See Bassiouni, *supra* note 7, at 297. Therefore, estimates of the incidence of mental illness that go as high as 95% of the population, see Robitscher, *supra* note 14, at 166, do not surprise or alarm clinicians, but are used by civil libertarians as examples of the unreliability of psychiatric diagnosis.

The arbitrariness of psychiatric diagnosis has been underscored by many authors as a result of changes in official clinical positions on whether such conditions as homosexuality and psychopathy are illnesses; less attention has been paid to judicial arbitrariness. See *id.* at 156 for a discussion of *Powell v. Texas*, 392 U.S. 514 (1968), in which the Supreme Court decided, by a five-to-four vote, that alcoholism is a disease. Is that determination any less arbitrary than voting on whether homosexuality is a disease?

Psychiatrists have been accused (fairly) of paternalism because of their assumption of control over their patients. See Livermore, Malmquist & Meehl, *supra* note 13, at 88. The implication is that the legal profession is not paternalistic, but in many ways attorneys and judges are paternalistic on a far grander scale. A number of civil libertarians, both attorneys and clinicians, have argued for the total abolition of involuntary commitment, see Ennis, *supra* note 15; New York Civil Liberties Union, *supra* note 12; Szasz, *supra* note 10, despite the fact that their view is contrary to society's wishes as expressed by its legislatures and courts. See E. Goffman, *Asylums—Essays on the Social Situation of Mental Patients and Other Inmates* 384 (1961): "[I]f all the mental hospitals in a given region were emptied and closed down today, tomorrow relatives, police, and judges would raise a clamor for new ones; and these true clients of the mental hospital would demand an institution to satisfy their needs." Notice that Goffman did not include psychiatrists in the group who would be clamoring for new institutions.

We submit that the civil libertarian who would arbitrarily decide to close down a system that society so obviously feels is needed is being far more paternalistic than the psychiatrist who works in that system but did not design it or decree its construction. We know of no psychiatrists who would hospitalize 100% of the population, which would be the logical counterpart of those who would hospitalize 0%.

The paternalism of attorneys is indirect and therefore less easily perceived. Several authors have emphasized recently that patient advocates (including attorneys) have power without responsibility for the results of their actions. See Lamb, *Securing Patients' Rights—Responsibly*, 32 *Hosp. & Community Psychiatry* 393 (1981); Rachlin, *Of the Shared Responsibility for Civil Com-*

mitment (paper presented at the 58th Annual Meeting of the Am. Orthopsychiatric Ass'n, Mar. 1981); Stone, *supra* note 97.

When attorneys express concern for the sometimes tragic results of their efforts, they are reassured that the adversarial system will protect the needs of their clients. See Galie, *supra* note 87. It is interesting to note that even Dr. Thomas Szasz, the arch anti-psychiatrist, admitted abandoning his absolutist position by initiating involuntary commitment proceedings himself when placed in a position of direct responsibility for the outcome of a clinical encounter with a suicidal patient. *Psychiatric News*, Feb. 6, 1981, at 6.

When Szasz and others argue for their viewpoint of complete individual responsibility for behavior, which would rule out all involuntary commitment and relegate even more of the mentally ill to the jails, upon whose authority are they proceeding? Not that of their "clients," of whom far more prefer hospitals to jails. (This was not always the case; conditions in most state hospitals have markedly improved, while penal facilities have generally deteriorated in the past decade.) And they certainly do not speak for "society," if the legislatures and courts are to be believed. What is the difference between a doctor saying, "You should take this medicine and come to the hospital, because I am a doctor and know what is best for you," and an attorney saying, "You should accept responsibility for your actions and go to jail, even though you might prefer to go to a hospital, because I am a lawyer and know what is best for you?"

The clinician's individual relation with patients is another source of conflict. Statements like, "In any social revolution, there will be casualties" (made by a former patient advocate in the North Carolina system, in reference to unfortunate results befalling a patient discharged by the court against the advice of his physician) are not calculated to convince clinicians who are not comfortable with any casualties, and who bear responsibility for patients whether they are in or out of the hospital. Once a patient is discharged from the hospital, the patient attorneys and advocates no longer accept responsibility for whatever may occur. Clinicians do not have that luxury.

The focus of civil libertarians on the admittedly severe problems of state hospitals (which continue to serve the great majority of severely mentally ill patients) has caused a marked decrease in the opportunities for patients to receive hospital treatment, without doing anything to create the less restrictive alternatives they demand. See Slovenko & Luby, *supra* note 134, at 192 (quoting an unnamed "crusader" who stated, "When you have Buchenwald, you do not worry first about alternatives to Buchenwald." *Id.* at 192). Unfortunately, without that worry, the realistic alternatives to Buchenwald are Auschwitz and Treblinka. See also Chambers, *Right to the Least Restrictive Alternative Setting for Treatment*, in *2 Legal Rights of the Mentally Handicapped* 991, 1009 (1973); Shah, *supra* note 11, at 699. Clinicians have called for less restrictive treatment settings for years, and have led the actual efforts to establish them, efforts presently stalled not in the hospitals but in legislatures dominated by attorneys. Judge Bazelon, *supra* note 133, at 130, echoes the challenge to lawmakers to provide support for treatment outside hospitals.

The lessons to be learned from the impact of the 1979 statutory changes in North Carolina, at least at John Umstead Hospital, are several:

(1) The philosophies and roles of attorneys can have at least as much impact upon the results of commitment hearings, both for commitment and release, as those of psychiatrists. Perhaps lawyers have more impact because the rules in court are made by attorneys and are couched in terms like "dangerousness," which psychiatrists cannot successfully employ but whose use has been forced upon them by the courts and legislatures in response to court decisions.

(2) When society, in terms of nonclinical, nonlegal participants in the commitment proceedings, is given a greater role, the result is greater use of commitment, not lesser.

(3) Fine distinctions in statutory definitions, like the precise meanings of words such as "dangerousness," "mental illness," and "grave disability" have little effect on the outcome of hearings.

(4) If society wants more people confined in mental hospitals, then provisions for outpatient treatment and due process requirements for adequate information on commitment will not impede attainment of that goal significantly.

If those who propose and draft future mental health statutes do not take these factors into consideration, they will have no more success with their new laws than we have had with the 1979 changes.

APPENDIX

Table 1

MENTAL PATIENTS

Physicians' Recommendations	Commit Inpatient	Commit Outpatient	Release	Total
March 1, 1979 to August 31, 1979	359 78%	14 3%	89 19%	462
October 1, 1979 to March 31, 1980	348 77%	13 3%	91 20%	452

INEBRIATES

Physicians' Recommendations	Commit Inpatient	Commit Outpatient	Release	Total
March 1, 1979 to August 31, 1979	22 6%	1 0.2%	339 94%	362
October 1, 1979 to March 31, 1980	46 10%	12 3%	401 87%	459

Table 2

MENTAL PATIENTS

Time Period	Patients Recommended for Commitment	Patients Committed	Patients Recommended for Release	Patients Released
March 1, 1979 to August 31, 1979	359	243 67%	89	84 94%
October 1, 1979 to March 31, 1980	348	310 89%	91	64 70%

Table 3

INEBRIATES

Time Period	Patients Recommended		Patients Recommended	
	for Commitment	Patients Committed	for Release	Patients Released
March 1, 1979 to August 31, 1979	22	11	339	335
		50%		99%
October 1, 1979 to March 31, 1980	46	32	401	390
		70%		97%

Table 4

Admissions by County Per 100,000 Population

	Emergency Commitments	Total Commitments
Rural Counties	124	201
Urban Counties	2.65	165
Close Counties	14.2	209
Far Counties	0.614	142