# THE DEVELOPING ROLE OF THE DEFENSE LAWYER IN MENTAL HEALTH LITIGATION

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## *Lawyers as Advocate-Negotiators*

The last decade has been one of substantial turmoil for the mental health system. This has been especially so in regard to the delivery of nonvoluntary mental health care. Critics from within and without the mental health professions have challenged the long-accepted philosophical foundations for compelling some persons to undergo treatment despite their protestations. In addition, there have been numerous changes in the legal framework for the provision of nonvoluntary care. Some of these changes have been legislative innovations, but many—perhaps most—have been the direct or indirect results of court orders following litigation based on alleged constitutional deficiencies in the existing systems.

One phenomenon that is to some extent the cause of and to some degree the result of these recent developments has been the recent tendency of lawyers to undertake an increasingly active role in mental health matters. Many mental health professionals find this new lawyer activism more difficult to understand and accept than the other changes that have occurred. Mental health personnel are both confounded and angered when lawyers pursue with vigor and skill objectives which the mental health workers believe—and which the lawyers frequently acknowledge—are inconsistent with the long-term "best interests" of the person involved.

The relationship between the new activist lawyers and mental health professionals tends to be an especially stormy one because it is through the lawyers' day-to-day efforts on behalf of their clients that the considerable changes that have been mandated for the mental health system are implemented so as to have a direct impact on the mental health workers.

This monograph explores several aspects of the new activist attorneys' behavior that may assist others in better understanding this relatively new breed of lawyer. Decisions that lawyers must make in defining their role in mental health matters and the reasons for the trend towards a "new" resolution of those decisions are examined. It is clear, however, that there are still significant impediments to universal acceptance of this activist role, and these hindrances are considered as well. An effort is then made to explain what the activist lawyers are doing and why they are undertaking these tasks in an effort to fulfill what they see as their newly recognized responsibilities.

### *Role Definition*

Traditionally—and currently, in many jurisdictions—lawyers have perceived themselves as having only a limited role in mental health proceedings. Although lawyers have been provided for proposed patients in civil "commitment" proceedings, these lawyers have generally done little more than represent the proposed patient during the actual court hearing. Moreover, during these proceedings the lawyers have regarded themselves as having the right—and even the duty—of making their own determination of whether the proposed treatment would be in the "best interests" of their clients and, if it would be, of not vigorously contesting the case.

The lawyer, in other words, has functioned much as a guardian, exercising the power to make critical decisions concerning the litigation for his client and then proceeding to implement those decisions. Andalman and Chambers, in "Effective Counsel for Persons Facing Commitment: A Survey, A Polemic, and A Proposal," *Mississippi Law Journal*, Vol. 45, page 43, at page 72, after investigating the performance of lawyers in mental health proceedings, gave the following description of attorneys' participation in several states:

> The attorneys did not in any way regard themselves as advocates and (partly as a consequence) failed to develop the knowledge or perform the work necessary to aid their clients. Indeed, they did virtually nothing except stand passively at a hearing and add a falsely reassuring patina of respectability to the proceedings.

If, for some reason, a lawyer was moved actively to resist the proceedings on behalf of his client, his efforts have traditionally been limited to courtroom advocacy of the traditional sort. Often the lawyer would do no more than strive desperately to discredit the psychiatric witnesses by finding minor inconsistencies in their description of the patient or his symptoms. Although this behavior corresponded reasonably well with the layman's image of an effective lawyer, it was seldom effective in persuading the judge or jury. It therefore was of little value to the proposed patient.

This perception of lawyers' role has recently been subject to increasing challenge. Lawyers participating in mental health litigation have become sensitive to the need to make two critical decisions concerning the nature of

their participation. One requires them to choose between the traditional "guardian" role and what might best be described as an "advocate" role. In the latter, the attorney's ultimate professional responsibility is to use all legitimate methods to pursue objectives defined by the client, rather than assuming responsibility for defining those objectives. The second decision requires a choice between the traditional "litigator" role in which the lawyer's major function is in-court representation and the "negotiator's" role, in which the lawyer also attempts to achieve the client's objectives by informal negotiation and bargaining.

Several interrelated but nevertheless distinguishable factors have been responsible for lawyers' recent tendency to resolve these questions more frequently in favor of an "advocate-negotiator" role.

*Constitutional Mandate*

A major aspect of the changes in the mental health system's legal framework has been the incorporation into that framework of procedural rights for the proposed patient. These have often been rights developed in criminal litigation and inserted—sometimes with modification to accommodate the different context—into the mental health system. The assumption upon which this incorporation has been based is that proceedings to compel a person to submit to treatment are "adversary" proceedings. Under this premise, an accurate outcome is best assured by providing a proposed patient with the opportunity to stimulate that clash of opposing views which will result in full exploration of all possible positions and the ultimate selection of the best solution.

Several courts have held that one of those rights to which a proposed patient is constitutionally entitled is representation by a lawyer who perceives his role as that advocate. A federal District Court in Alabama stated the basic proposition as follows:

> The right to counsel is a right to traditional counsel occupying a traditional adversarial role. Where state law requires or permits the appointment of a guardian *ad litum*, such appointment shall be deemed to satisfy the constitutional right to counsel if, but only if, the appointed guardian is a licensed attorney and occupies a truly adversary position.

Lynch v. Baxley, 386 F. Supp. 378, 389 (M.D. Ala. 1974). There is increasing recognition, then, that a lawyer who fails to structure his role as that of an advocate violates one of the client's federal constitutional rights. Since vigorous and skillful advocacy is often essential to the implementation of other procedural rights available to a proposed patient, it is arguable that this right to representation by an advocate is the most important of those developed in recent reform efforts.

Recent consideration—prompted no doubt in part by the judicial decisions discussed above—has suggested to many lawyers that vigorous pursual of the advocate role is not only consistent with but mandated by long-recognized professional standards. Canon 7 of the Code of Professional Responsibility, adopted by the American Bar Association, states that "the duty of a lawyer, both to his client and to the legal system, is to represent his client zealously within the bounds of the law". But it also recognizes that the lawyer's role includes advising the client on matters of judgment:

> A lawyer should exert his best efforts to insure that decisions of his client are made only after the client has been informed of relevant consideration. . . . A lawyer ought to initiate this decision-making process if the client does not do so. Advice of a lawyer to his client need not be confined to purely legal considerations. A lawyer should advise his client of the possible effect of each legal alternative.

It is clear, then, that the advocate's role does not prohibit an attorney from advising a proposed patient that hospitalization or other treatment would, in the attorney's judgment, be appropriate and helpful. To the contrary, an attorney representing a proposed patient who seeks to resist hospitalization has a recognized duty to advise his client concerning the attorney's judgment as to whether resistance would be wise.

But it is also well-established that in regard to matters substantially affecting the right of the client, the client holds the ultimate power of decision-making. According to Canon 7, "the authority to make decisions [affecting the merits of the cause or substantially prejudicing the rights of a client] is exclusively that of the client and, if made within the framework of the law, such decisions are binding on the lawyer." The duty to counsel a client as well as to pursue his ultimate decision is caveated by the warning that "in the final analysis, however, the lawyer should always remember that the decision whether to forego legally available objectives or methods because of non-legal factors is ultimately for the client and not for himself." In practical terms, this means that the lawyer maintains sole authority to make tactical and procedural decisions, such as what witnesses to call and what objections and motions to make. But the client must make such basic decisions as whether to resist actively efforts to compel him to submit to treatment, whether to demand a jury trial if one is available, and—if a choice is available—whether to take the witness stand and testify in his own behalf. While the lawyer may advise the client on these matters, he must take care not to characterize inaccurately the alternatives or to impede the client's ability to make an independent choice. Given the fact that proposed patients are often emotionally and intellectually impaired, the need to avoid overbearing their decision-making capacity is especially great and, in many cases, presents an unusually difficult task for the lawyer. The most that can helpfully be said as a general matter is that the lawyer's role as advocate does not affect his role

as counsellor, but in mental health proceedings lawyers need to be exceptionally sensitive to their duty to avoid overbearing the will of clients likely to be susceptible to such influences.

Does the fact that the client may be mentally ill and substantially impaired affect the application of general professional standards to the lawyer's role in mental health proceedings? Some have argued that this characteristic of mental health proceedings has no significance. The purpose of the proceedings, it is asserted, is to determine whether the proposed patient is mentally ill and, if so, sufficiently disabled to bring him within the group of persons who will be compelled to submit to treatment. To modify the lawyer's role on the basis of an assumption concerning the outcome of the proceeding would be to depreciate the proceeding itself in unacceptable fashion.

But the Code of Professional Responsibility suggests that the answer is not so simple. Canon 7 states that "the responsibilities of a lawyer may vary according to the intelligence . . . [or] mental condition . . . of a client" and "any mental . . . condition of a client that renders him incapable of making a considered judgment in his own behalf casts additional responsibilities upon his lawyer." The Canon then specifies that if a client is under disability and has no formally appointed guardian, the lawyer may be compelled to make certain decisions on behalf of the client. The section closes, however, with the admonition, "But obviously a lawyer cannot perform any act or make any decision which the law requires his client to perform or make." The meaning of this language is not entirely clear. It is best read, however, as simply recognizing that the fact that the client's mental health and emotional or intellectual capacity has been challenged has no effect upon the need for the client to make the basic decisions identified earlier. A lawyer's conscientious determination that the client's judgment is impaired may, however, increase the number of non-fundamental tactical decisions the lawyer may make and decrease the obligation to consult with the client before making them. A lawyer who believes, after adequate inquiry, that his client's judgment is substantially impaired may have less of an ethical obligation to consult with the client concerning which witness to call and how vigorously to cross examine witnesses presented by the other side. He still, however, may not decide for the client whether or not to contest the proceedings, and his client's impairment probably increases his need to avoid overbearing his client's capacity while providing advice on whether or not to resist hospitalization efforts.

### *Practicality*

Once lawyers began to take seriously the task of assisting proposed patients in avoiding treatment, it became clear that this could not be performed simply by courtroom advocacy. There were, of course, numerous models available for providing a broader range of services for the client. Pretrial compromise settlements in civil litigation are common, and an attorney is

often able to maximize his client's benefits by this means rather than going through a trial. In the majority of criminal cases, the chances of winning a trial are so remote that it is seldom to a client's advantage to litigate the matter. In such situations, the lawyer's function is often best performed by assisting the client in making an attractive case for a lenient sentence. This may involve assisting the client in obtaining a job or enrolling in a vocational training course. Advocacy, in these situations, is performed by negotiation and careful preparation of a nonlegal case.

It was inevitable, then, that lawyers who took seriously their advocate's role would become negotiators as well as litigators. This function involved at least two distinguishable types of activity. The first includes efforts to implement "legal" rights, but by informal means. The lawyer may, for example, seek to participate in the client's evaluation by a mental health facility in an effort to persuade the examiners that the client does not meet the legal standard for commitment. This effort, of course, is aimed at winning the "legal" issue of whether there is sufficient proof but to do so without the necessity of formal trial. The second type of activity consists of attempts to maximize a client's advantage by non-legal methods. A lawyer representing a client whose hospitalization is sought by the client's spouse, for example, may attempt to find resources for the family unit to enable the family to accept the client back and to persuade them to do so, even though there may be sufficient evidence available to justify hospitalization. This plan amounts to securing for a client an advantage to which he has no identifiable legal right but which, as a practical matter, is available to him in some situations. Activity of both sorts often involves cooperation with mental health personnel and active participation in nonjudicial stages of the mental health system. But in many cases this effort enables the lawyer to implement more effectively the client's desires than would be possible by even the most effective courtroom techniques.

### *Barriers to Effective Fulfillment of Advocate-Negotiator Role*

Despite the growing acknowledgement of the theoretical desirability of the advocate-negotiator role, it is clear that lawyers representing proposed patients do not always so define their duties to their clients. Some explanations are relatively simple. If a proposed patient is so uncommunicative that he expresses no discernable views, the incentive to undertake vigorous representation of the person is greatly reduced. To some extent, inertia is influential. A major change in role requires that long accepted practices be abandoned, often with difficulty. But there are also more important factors that need to be addressed specifically because of their tendency to increase the difficulty of fulfilling what is increasingly recognized as the legally and ethically required role of a lawyer.

First of these considerations is lack of knowledge. Mental health diagnosis and care are specialized areas with which many lawyers have no more than passing familiarity. If a recognized mental health professional asserts that a proposed patient "needs" hospitalization, a lawyer with little background in the area is often quite uncomfortable in undertaking to challenge this assertion. Effective performance of the negotiator role requires that the lawyer be able to discuss diagnosis, treatment techniques, and community resources. Lack of such ability discourages and precludes lawyers from undertaking effective advocacy in this fashion. The matter is aggravated by the absence of circumstances encouraging the development of familiarity with the background information necessary for effective advocacy. Mental health proceedings are relatively infrequent and often involve proposed patients with minimal financial resources. There is little financial incentive for lawyers to develop in this area the expertise that exists in such fields as patent and communication law. Young attorneys asked to undertake mental health cases once or twice a year have little incentive to build up a body of background information for these cases, since they will seldom find use for it in other areas of their practice. This has a dual effect. It discourages lawyers from challenging mental health experts, an essential factor to the advocate role. In addition, it reduces the effectiveness of those lawyers who, despite the discouragement, nevertheless undertake vigorous representation of the wishes of the proposed patient.

A second factor is the ambivalence experienced by many lawyers concerning their role. Assumption of the advocate role requires a lawyer to resist with all professional skills the compulsory treatment of proposed patients he or she may believe would be benefited by the proposed treatment. Natural humanitarian impulses often make this an uncomfortable task. Undoubtedly many lawyers are unwilling to completely suppress such impulses, and as a result they may accept a compromise role perspective somewhat closer to the guardian role than that the advocate described earlier.

A third barrier is the frequent absence of vigorous representation for the "other side." Recent reform efforts have sometimes resulted in the provision of adversary representation for the proposed patient but not equally motivated or skilled representation for the person or institution seeking involuntary care. As a result, counsel for a proposed patient may anticipate winning for reasons unrelated to the merits of the proposed patient's case. For example, the absence of a crucial witness because of the lack of preparation of opposing counsel may result in a victory because those seeking involuntary care have not been able to establish certain facts which counsel for the proposed patient knows to be true.

The advocate's role is justified on the ground that the most nearly "correct" disposition of a case is likely to arise from a vigorous clash of conflicting views; the role—and responsibility—of those presenting the conflicting views need not go beyond this task of presentation. But where equality of representation does not exist, the justification for assigning defense counsel no responsibility for the outcome of the proceeding disappears. A number of lawyers undoubtedly are dissuaded from unqualified acceptance of the advocate role because they perceive the mental health system as one in which a clash of equally skilled and prepared advocates is not assured and therefore one in which adoption of the advocate role creates an unacceptable risk of inaccurate results.

A final element militating against adoption of a "pure" advocate role is resistance by other participants in the mental health system. Trial judges who actually hear litigated cases are likely to be especially influential. The power of a trial judge is vast and largely immune from efforts at control. A local trial judge who opposes vigorous advocacy on behalf of proposed patients may exert considerable informal influence upon lawyers, tending to discourage them from adopting this role. A young lawyer, struggling to develop a practice, may find such pressure impossible to resist. Even if the lawyer is willing to ignore efforts to discourage him from performing as an advocate, the fact that the trial judge disapproves of rigorous advocacy of proposed patients may require the lawyer, in the best interests of his clients, to adopt a modified role, at least when appearing before the judge. The best possible representation of a proposed patient who may come before such a judge often consists of avoiding direct confrontation in open court and instead pursuance of other methods, such as informal negotiations with the institutional staff.

These factors explain to some extent the relatively common reluctance of lawyers to accept the advocate-negotiator role without qualification. Some of

the factors represent defects in the legal system that should be modified: lawyers should be compensated adequately to enable them to prepare effectively for litigation; adequate representation should be provided for those persons seeking hospitalization of others as well as for proposed patients; trial judges should not use their discretionary power to impede the performance of proper roles by lawyers. At least one factor suggests that inadequate consideration may have been given to the desirability of establishing those "rights" which an advocate-negotiator must pursue for his client. Insofar as conscientious lawyers continue to experience ambivalence when confronted with the task of implementing a relatively narrow standard for determining which mentally ill persons will be compelled to undergo treatment, the propriety of that narrow standard seems to be called into question. The discomfort experienced by lawyers who must actually enforce these standards on a day-to-day basis may be a reasonably accurate indicator of the acceptability of these standards to the community at large. It does seem clear that until defects in the legal system are repaired and until it becomes widely-accepted that narrow commitment standards are based upon sound considerations, there will continue to be strong pressures upon lawyers to avoid full embrace of the advocate-negotiator role.

### *Implementing the Advocate-Negotiator Role*

How might a lawyer who concludes that duty requires him to perform as an advocate-negotiator seek to fulfill this responsibility? A basic understanding of the mental health litigation process is a necessary prerequisite to any discussion of the opportunities it presents to such lawyers. Although procedures differ to some extent from jurisdiction to jurisdiction, most follow a common pattern.

Proposed patients are usually first hospitalized under "emergency" authority that requires no court approval or, if court approval is necessary, no formal hearing. A petition is then filed for formal proceedings leading to long-term treatment. After the initial admission, an opportunity for a formal court hearing is extended. This hearing is likely to be held within several days or weeks from the initial admission. At the hearing, a right to jury trial may or may not be available, depending upon the law of the jurisdiction. Testimony is taken from sworn witnesses. The judge—or the jury, if the case is tried to a jury—determines whether the evidence proves that the proposed patient meets the standard set out by state law determining which persons may be compelled to submit to treatment. In some jurisdictions, the petitioner must prove that the proposed patient is "dangerous to himself or others", while in others it is sufficient if it is established that the proposed patient is "in need of care and treatment". The criteria differ widely in phraseology.

Traditionally, the only option available to the court if it was determined that the proposed patient met the statutory standard was to order full-time hospitalization. In an increasingly large number of jurisdictions, however, the court is given the alternative of ordering the person to submit to treatment programs not involving full-time institutionalization, such as day-care programs or even out-patient therapy. The old term "commitment", insofar as it implies court-ordered hospitalization, is no longer an accurate description of mental health proceedings in many jurisdictions.

In most jurisdictions, a proposed patient who is found to meet the statutory standard and is ordered to submit to treatment may appeal the decision of the trial court to an appellate court. The appeal is "on the record." This means that the appellate court considers only the testimony and evidence that was presented before the trial court. No new testimony is taken before

the appellate court, although both written and oral arguments may be presented before this tribunal. The appellate court does not decide any issues as if they were before it for the first time, but rather reviews the documents in the case and the transcription of the testimony to determine whether errors were committed by the trial court.

A proposed patient or his family may, of course, retain an attorney to represent the proposed patient, and such a privately-retained lawyer may enter the proceedings at any time. But most mental health proceedings involve indigent proposed patients who are unable to hire their own attorneys. Lawyers are uniformly provided for such proposed patients—the lawyers are "appointed by the court"—although the time at which this occurs varies tremendously. In some jurisdictions, a lawyer is appointed when the proposed patient is first admitted or soon after; in others, the lawyer is not appointed until minutes before the actual court hearing. There is general agreement that an appointed attorney is entitled, upon request, to adequate time to prepare a defense.

It is useful to discuss the way in which a lawyer might function in each of the three identifiable stages of the litigation process: the pretrial stage lasting from initial admission to the beginning of the hearing, the hearing itself, and the post-hearing appeal process.

### *Pre-hearing*

Counsel's first duty during the prehearing stage is full investigation of the facts. This study requires a careful examination of any hospital or medical records concerning the proposed patient, of course, and consultation with any hospital personnel who are involved with the proposed patient. In addition, counsel should usually make an independent investigation of the events leading to the demands for the proposed patient's hospitalization. This search will generally require interviewing persons in the community, especially those seeking the proposed patient's commitment. The lawyer should be alert to factors bearing upon the proposed patient's ability to survive in the community and to any potential resources that may not yet have been utilized to the fullest possible extent. Given (1) the increasing recognition that the need for hospitalization is often as much a function of the proposed patient's social and community situation as of his clinical pathology and (2) the difficulty that institutional staff members often have in making a full investigation of the community situation, counsel can serve his client well by stressing this aspect of the pretrial investigation.

If the proposed patient has been hospitalized and an evaluation will take place during this prehearing period, the lawyer should also consider seeking permission to attend the meeting of the institution's staff at which the proposed patient will be discussed. Efforts to establish a legal right to attend such staffings have generally failed. But some institutions, at least, permit and even encourage lawyers' attendance. More might do so if it were demon-

strated that a lawyer's presence and even active participation need not be disruptive. The lawyer should recognize that these staffings are not the place for courtroom theatrics. Rather, he should offer information which the staff may not have had an opportunity to gather and point out those aspects of the situation that favor the proposed patient. This is also an opportunity to gather information that might be useful if the matter does go to a formal hearing. If there is disagreement among the staff members as to the recommendation to make, counsel should note those staff persons appearing to favor the proposed patient and should consider them for possible use later as witnesses. Attention also should be given to the facts and information considered by the staff in arriving at their conclusions; this may be useful in cross examining any staff members who testify at trial.

During this prehearing period, the lawyer can also undertake to make hospitalization or even court-ordered outpatient care unnecessary. Placements that will be accepted voluntarily by a proposed patient who acknowledges a need for assistance but resists hospitalization in a psychiatric facility can sometimes be located. Nursing home facilities, for example, are often more appropriate for elderly persons than state hospital placements. While institutional staff members may have formal responsibility for examining alternatives to full-time hospitalization, the lawyer cannot rely upon their conclusions that no such alternatives are available. The understaffing of many institutions means that social workers and others are sometimes unable to make as thorough a scrutiny of community resources as is desirable. To some extent, the practice of law here as elsewhere necessarily also involves the practice of social work.

Throughout this prehearing period, the attorney should be in contact with the proposed patient and counselling him. He should advise the proposed patient concerning the wisdom of resisting treatment, but only after obtaining sufficient information to make this counsel soundly based. A continuing effort must be made to preserve the proposed patient's ability to make as free choice as possible concerning whether or not to resist the proceedings.

Special attention should be given the need to advise the proposed patient concerning "going voluntary," i.e., admitting himself to hospitalization on a voluntary basis. In some situations, of course, this is a desirable course of action and defense counsel should so advise the proposed patient. If hospitalization is inevitable, there is evidence that it will be more beneficial for the patient if it is accomplished on a voluntary basis. Staff members tend to be more favorably inclined towards voluntary patients, and staff attitude may have a significant effect upon the benefits a patient derives from hospitalization. However, the attorney must exercise caution to prevent both the lawyer and the proposed patient from uncritical acceptance of voluntary admission as the "easy way out" of a situation that may be painful for both.

Defense counsel should be alert to frequent informal pressures by family or staff that sometimes render voluntary admissions voluntary only in label. Patients are sometimes advised that formal hearing will only result in commitment and therefore voluntary admission is simply the easiest method

of accommodating the inevitable. This may, of course, be correct. But the attorney should make full investigation before so advising the proposed patient and should stress that if the proposed patient wishes to resist despite the unfavorable prognosis the lawyer will assist him fully.

The lawyer should also be certain that the proposed patient understands the legal effect of a voluntary admission. In most jurisdictions, a so-called voluntary patient may be retained in the hospital for a limited period of time after formal notice of intent to leave is given. During this period, involuntary commitment proceedings may be begun. Thus, it is important that the proposed patient realize that after voluntary admission he is not free to leave the facility upon request and may, in fact, not be able to leave it even after giving notice the required period in advance.

The lawyer also should be aware of the increasing evidence that hospitalization often is not only unnecessary but may be harmful to the proposed patient. It may reduce the person's incentive to adjust to community life. By breaking already tenuous ties to community resources such as jobs, it may increase the difficulty of such adjustment. The proposed patient's family and the institutional staff are unlikely to present a fully balanced picture of the merits and disadvantages of hospitalization. The lawyer should seek to balance this, even if the task requires that he play the role of "devil's advocate" to some extent.

If the proposed patient does elect to admit himself on a voluntary basis, the attorney should not regard his responsibility as fully discharged. Given the danger that informal pressures may prevent a voluntary patient from exercising his right to leave the institution—or at least to attempt to leave and thereby require the staff to pursue formal commitment proceedings—the lawyer should regard himself as having a continuing duty to assure that the patient remains aware of his legal status and as free as possible to exercise legal options. This fact need not interfere with treatment efforts. In fact, many mental health personnel would argue that the continuing and active iterest of a person in the community—such as a lawer fulfilling the responsibility suggested above—is likely to encourage the patient to continue to pursue the goal of return to the community.

### *Hearing*

If the matter goes to a formal hearing, the role of defense counsel changes somewhat. While still an advocate, the lawyer has—temporarily at least—exhausted the possible benefits to be derived from negotiation and must shift to traditional litigation skills. Recent legislation, judicial decisions, and empirical studies of the diagnostic and treatment processes combine to create numerous opportunities for a vigorous lawyer to use on behalf of a proposed patient in this context.

First, the lawyer may assert a number of established or developing procedural rights of the proposed patient. These are generally rights regarded

by those who favor them as ultimately assuring increased accuracy in mental health litigation. To achieve maximum effectiveness, they must be made available in all cases even if in some they appear to accomplish little in terms of accuracy of outcome. A lawyer may, then, assert that his client's rights were violated and his client is entitled to have the proceedings dismissed even if there was no apparent danger that *in this case* the violation did or would result in an inaccurate result. Some of those rights an attorney might reasonably seek to assert are as follows:

*Invalid Emergency Detention.* Counsel might argue that the proposed patient's emergency detention was invalid, either because no actual need for immediate detention existed or—if the detention was under a court order—the judge who issued the order did not have sufficient information at that time to make a realiable determination that such a need existed. Since the period of emergency detention ends with the formal hearing, the lawyer may argue, the only way to deter such improper detentions is to prohibit use of any information obtained during the emergency detention. Thus, counsel may object to the testimony of a psychiatrist who examined the proposed patient during the period of emergency detention on the ground that the psychiatrist's testimony was "tainted" by the illegality of the detention and should not be heard.

*Inadequate Notice.* Proposed patients have traditionally been served, before the hearing, with notice that a petition for their commitment has been filed, that a hearing will be held, and the time and place of the hearing. Defense counsel can argue, however, that this minimal notice is insufficient to permit the preparation of an adequate defense. It can be argued that the proposed patient and his attorney are entitled to advance notice of the specific reasons why it will be asserted the proposed patient is subject to involuntary treatment, the names of those persons who will testify, and the substance of their testimony. Only if this information is provided and only if the petitioner is required to limit himself to those matters can the defense adequately prepare in the short time available to test the accuracy of the witnesses' testimony.

*Right Against Self-Incrimination.* The Fifth Amendment privilege against self-incrimination protects a person from being compelled to give information orally that would in any way tend to result in conviction of a crime. Defense counsel can argue that since conviction of a crime and involuntary mental health treatment both involve deprivation of liberty, "incrimination" should be read as also including "involuntary treatment." Thus a proposed patient can be said to have a legal right to avoid giving information that would tend to cause him to be committed. Defense counsel can argue that at the hearing the proposed patient cannot be called as a witness by the petitioner and compelled, under threat of contempt of court, to give testimony supporting the petitioner's case. Further, counsel can argue that a prehearing psychiatric

interview violated this right unless the attorney was present to assure that the proposed patient was aware of this right or some other precautions were taken to assure that the proposed patient knew of the right to refuse to answer and how to assert it.

*Right to be Present.* In some jurisdictions, the hearing can be held without the proposed patient if there is medical testimony that the proposed patient's presence would be harmful to him. Defense counsel can argue that due process requires that the proposed patient be given the option to be present even if this might result in discomfort to him. Only if the proposed patient is present and hears the testimony can the lawyer learn which portions of the testimony should be attacked. There is, defense counsel can assert, no reliable evidence that a proposed patient's presence at a hearing will result in long-term impairment of recovery capacity, although presence may quite obviously be temporarily upsetting.

*Right to Confront Witnesses.* The Sixth Amendment right to confront witnesses produced against one, defense counsel can argue, applies to civil commitment hearings as well as criminal trials. As a consequence, the court should hear no evidence as to what a person said unless the witness makes the statement in open court and is subject to cross examination concerning the accuracy of the statement. If, for example, a psychiatrist offers during his testimony to relate what the proposed patient's family told him about an incident involving the patient, defense counsel might object on the ground that this amounts to having the proposed patient's family testify and is permissible only if the family members themselves appear in court, testify to the incident, and subject themselves to cross examination concerning the accuracy of their testimony.

*Burden of Proof.* In many jurisdictions, it is unclear what measure of burden of proof is or should be imposed upon one seeking to submit another person to involuntary treatment. In ordinary litigation, the party seeking relief need only prove his case by "the preponderance of the evidence." This means that more—but only slightly more—evidence must favor his own version of the facts than favors his opponent's version. In criminal prosecutions and in proceedings to declare a juvenile delinquent, the defendant's (or the youth's) guilt must be proved by evidence "beyond a reasonable doubt." It can be argued that in mental health proceedings due process of law requires proof that the proposed patient meets the statutory criterion "beyond a reasonable doubt" or at least proof that meets the slightly less stringent standard of "clear and convincing" evidence. Opponents of these high burdens of proof argue that given the difficulty of diagnosis and predicting behavior, these burdens place an impossible task upon those seeking hospitalization of another. But counsel for a proposed patient can argue that because of the danger of inaccurate diagnosis and predictions created by the state of the art, it is especially important to assure that the proof is especially reliable before it is used to deprive a person of liberty.

Other procedural rights may be asserted, of course. The often-complex requirements of local law may provide numerous opportunities to make such arguments. What is important to note, however, is that most of these procedural rights are designed to increase the adversary nature of the hearing by enabling the proposed patient's lawyer to prepare more effectively to challenge testimony produced by the petitioner. Underlying the arguments for these rights, then, is the assumption that the more adversary the hearing, the more likely it is to produce an accurate outcome.

A second kind of challenge a lawyer may raise deals with the standards for determining what persons are subject to involuntary treatment. Two challenges are often possible. The constitutional requirement of due process demands that standards used by the law be sufficiently precise in order that it can be determined before one acts what behavior will result in legal liability and in order that it can be determined during litigation of a case what facts it is necessary to show in order to win. Defense counsel may argue that the criteria provided by statute are so unclear as to be unconstitutionally vague. If the statute requires proof that the proposed patient is "dangerous to himself," defense counsel may argue that it is unclear whether it is necessary to prove that the proposed patient will, if not treated, do immediate physical harm to himself. The statute does not clearly indicate whether it is sufficient that the petitioner prove that if not treated the proposed patient will experience a decline in mental—and perhaps physical—health over a sustained period of time. The lawyer may also challenge the criteria as unconstitutionally "overboard." It can be argued that some reasons for which hospitalization might be sought are so insubstantial that to hospitalize a person on that basis violates basic due process rights. In *O'Conner v. Donaldson*, for example, the United States Supreme Court stated that mentally ill persons could not be hospitalized simply because hospitalization would "ensure them a living standard superior to that they enjoy in the private community" or to save other people from "exposure to those whose ways are different." To hospitalize a mentally ill person on such insubstantial grounds, the Court held, would violate "every man's constitutional right to liberty." Defense counsel may argue that if the statute requires only proof that the proposed patient is "dangerous to himself," this permits hospitalization only because the person is not able to maintain a middle-class living standard and therefore the statute is unconstitutionally overbroad. If the court is unwilling to hold the commitment statute invalid, defense counsel may argue for a favorable interpretation of it. Ambiguities in the statutory standard, it can be asserted, must be resolved by interpretation so that the standard is a meaningful criterion for use in deciding the case before the court.

He may, for example, argue that if the statute requires proof that the proposed patient is "dangerous to himself," the court should interpret this for purposes of the case as requiring that the proposed patient would commit suicide if not hospitalized. The court may regard it as necessary to interpret

the statute narrowly and specifically to blunt defense counsel's arguments of vagueness and overbreadth.

Third, the lawyer may—in those jurisdictions in which the right is available—assist the proposed patient in invoking the right to trial by jury. This procedure, however, is likely to be less effective than is commonly assumed. While lawyers' views concerning jury decision-making are based upon impressionistic observations during trials, most trial attorneys would agree that a jury is usually less desirable in a "close" commitment case than a conscientious trial judge. Such cases require the person or persons making the decision to put aside natural humanitarian impulses and objectively apply a moderately technical criterion. It is likely that jurors are more likely than a trial judge to be swayed by the irrelevant but appealing emotional aspects of the close case. Nevertheless, in many jurisdictions the right to jury trial is an important part of the process. There appears to be general agreement that if jury trial is available, the decision as to whether or not to invoke it should be that of the proposed patient himself. Counsel, however, should offer advice concerning the impact of invoking the right or waiving it as well as offering professional opinion as to wisdom of alternative courses of action.

A fourth kind of effort that an attorney can undertake at trial—perhaps the most important one—is vigorous challenge of the petitioner's expert witnesses. Petitioners' evidence in civil commitment cases has traditionally been primarily the testimony of experts such as psychiatrists and psychologists. Usually witnesses are permitted only to testify to their opinions concerning matters within their field of expertise. These expert opinions have been the traditional and major source of evidence supporting civil commitments. But recent efforts to evaluate the accuracy of clinical judgments provide defense counsel with potentially effective tools to attack this testimony.

Several types of attack may be made. Defense counsel may challenge a witness's expertise and ask that the court not regard the witness as an expert qualified to express an opinion. For example, a psychiatrist may offer to testify that a proposed patient is, in his opinion, likely to assault other persons and therefore is dangerous. Defense counsel may, while acknowledging the witness's expertise on diagnosis and treatment, argue that the witness does not possess demonstrable skills in predicting behavior. He may cite studies of persons diagnosed as dangerous by mental health professionals but nevertheless released by courts. When followed up, fewer than one-half of these persons were found to have committed serious assaultive crimes.

If defense counsel is not successful in preventing a witness from being qualified as an expert, there are still alternative grounds for attack. Traditionally, experts have been asked simply to state their conclusions and little more. The lawyer for a proposed patient may, however, demand on cross examination that the witness explain in great detail the facts relied upon in forming that opinion and the reasoning process by which the witness progressed from those facts to the ultimate opinion. This procedure may open several further opportunities. Full disclosure of the facts and reasoning

process may convince the judge or jury that the expert really does not have sufficient information or reasoning abilities to justify the acceptance of his opinion. Or, defense counsel may be able to show that some of the facts relied upon by the expert were incorrect and thus convince the judge or jury that the opinion is therefore unreliable. If, for example, the expert knowledges relying upon a report that a proposed patient made an unprovoked assault upon another person, defense counsel may prove that the assault was in fact provoked. This point may lay the groundwork for an argument that the opinion should not be weighed heavily.

A witness may also be asked to defend his testimony in light of what defense counsel presents as the opinions of recognized experts or the results of authoritative studies. Defense counsel may use this technique in an effort to establish that the witness's opinion is not adequately supported by generally-recognized professional standards or authorities and therefore should not be given weight.

A witness who has testified that a proposed patient suffers from a certain illness—such as schizophrenia—may be questioned concerning the likelihood that another expert would agree with this diagnosis. Defense counsel may be able to relate the results of studies showing what some persons regard as a distressingly low rate of agreement among different diagnosticians and to query the witness concerning what basis he has for believing his diagnosis to be freer from professional dispute than those studied in the research. A psychiatrist who has testified that a proposed patient will, if not hospitalized, assault other persons may be asked about followup studies of persons regarded as dangerous. He may be queried as to whether he regards his prediction as more accurate than those predictions studied and—if he responds affirmatively—questioned as to why he does so. He may also be read the written opinions of a variety of generally recognized experts in the field of mental health to the effect that dangerousness cannot be predicted. He may then be asked to explain how he can assert the contrary.

A psychiatrist who has testified that a proposed patient "needs hospitalization" can be asked about studies of persons who have left psychiatric hospitals against medical advice. Followup comparison of these persons with others who remained hospitalized until evaluated by the staff as ready to leave show no significant difference in adjustment to community life. The witness can be asked whether these studies show that the need for hospitalization—or continued hospitalization—cannot be accurately determined and to explain how the study results affect his assertion that he can predict this. Although the extent to which a lawyer will be permitted to use such studies and items from the professional literature as well as the manner in which he will be able to present them differ from state to state, the increasing literature reporting empirical tests of clinical judgment is everywhere, to some degree, a potentially valuable tool for a lawyer seeking to perform the role of advocate.

A final possible effort defense counsel might use is the presentation of an affirmative case for the position that the proposed patient does not meet the

statutory standard. In theory, a proposed patient is required to produce no "defense" but may rely solely upon the argument that the petitioner has failed to meet his burden of proving that the proposed patient meets the statutory standard. But as a practical matter, some affirmative evidence contradicting that of the petitioner is probably essential if the petitioner has made any significant showing at all.

Several kinds of evidence might be produced on behalf of a proposed patient. Expert testimony that the proposed patient is not mentally ill or, if mentally ill, does not meet the statutory standard is valuable but difficult to obtain in many jurisdictions. If the proposed patient has been evaluated at an institution, the attorney should inquire as to whether any members of the staff disagreed with the ultimate recommendation that the proposed patient be hospitalized. Any such dissidents are potential defense witnesses, and their view should be investigated.

Defense counsel may also call lay witnesses to testify concerning the proposed patient's ability to survive in the community. Experience has taught that even severely ill persons are often able to live and function in the community despite substantial impairments. In many cases, the proposed patient will have lived in community despite symptoms no less severe than those present at the time of the hearing. In such cases, defense counsel might call as witnesses persons who dealt with the proposed patient in the community and who are willing to testify that, from their experience, the proposed patient—although ill—has been able to get by in the past. Neighbors and relatives might be considered, and even tradepersons or storekeepers with whom the proposed patient did business might be valuable sources of defense testimony.

The question of whether the proposed patient should himself take the witness stand and testify is often a difficult one. If the proposed patient does testify, he is subject to cross examination by counsel for the petitioner, and, this procedure may prove devastating. Exhibition of bizarre behavior in the courtroom is likely to be fatal for the defense case. On the other hand, it is essential to a successful defense that the proposed patient convey to the judge or jury the impression of being able to function reasonably well. In some cases, this can be done by demonstrating an ability to testify in his own behalf—and to stand up under cross examination. But in other cases, defense counsel might reasonably conclude that the same objective can be accomplished by having the proposed patient talk with the attorney in the courtroom and otherwise appear—without actually testifying—to be actively participating in the litigation. The ultimate decision as to whether or not to testify should be that of the proposed patient. But counsel should not be reluctant to offer information on the likely effect of testifying or not, as well as an opinion as to which course of conduct would be wiser.

## *Appeal*

In most jurisdictions, a proposed patient who is ordered by a trial court to submit to treatment may appeal this decision to at least one higher appellate court. Traditionally, however, such appeals have not been an effective procedure for the patient. One reason is mechanical. Preparation of the documents for appeal—especially the transcription of the trial testimony—often requires a substantial period of time. Generally, appellate courts will not consider an appeal that is "moot," i.e., that involves a matter that no longer makes any difference to the parties of the lawsuit. Given the frequent use of short-term hospitalization, it is common for a committed patient to be discharged before an appeal can be taken, with the result that already expended efforts to secure an appellate ruling are for naught. Even where the likely duration of hospitalization is uncertain, the danger that the case will become moot discourages many lawyers from beginning the appeal process.

Another reason appeals have not been effective has been the attitude of appellate courts. Generally, an appellate court will reverse the decision of a trial court if any substantial error was commited during the trial, such as the admission of inadmissible evidence or an erroneous or incomplete instruction to the jury as to how they should consider the matter. But when a trial has been held before a judge rather than a jury appellate courts require a significantly more important error before they will reverse the trial court. Mental health proceedings are usually conducted before a judge, and, therefore, the task of persuading an appellate court to reverse a commitment is a difficult one. Moreover, if it is clear that the proposed patient was seriously ill and that hospitalization was sought in good faith, there is a discernable tendency upon the part of appellate courts to ignore errors that would generally be regarded as requiring reversal and to affirm the trial court. Not only has it been difficult to get mental health cases before appellate courts, but once there it has been difficult to persuade the court to reverse the commitment for even acknowledged errors.

However, there is a need for more frequent consideration of mental health cases by appellate courts. Wide gaps exist in the law applicable to mental health proceedings, and many matters—such as the arguably vague standards for commitment—clearly need definitive consideration by appellate judges. Moreover, many present statutes are outdated and are subject to attack on constitutional grounds, yet action by the legislature is often difficult to stimulate until an appellate court has declared the statute unconstitutional. The mental health litigation system is sorely in need of the broad supervision that can be accomplished only by frequent and careful consideration of trial court decisions by an appellate tribunal.

Both lawyers and appellate judges are beginning to realize this fact. During the last several years, a discernable increase can be noted in the willingness of appellate courts to ignore mootness and carefully to consider arguments raised by appealing mental patients. Perhaps most important to the activist

lawyers has been the courts' increased willingness critically to evaluate expert testimony and reverse commitments where the evidence, considered carefully, does not adequately support the proposition that the proposed patient meets the statutory criteria. A Texas appellate court reflected this trend when it recently reversed the commitment of a proposed patient on the ground that the expert witnesses had testified only to their ultimate conclusions. If the jury was to make a meaningful evaluation of the evidence, the court reasoned, the factual basis for the experts' conclusions as well as the conclusions themselves should be before the jury:

> Expert testimony that a person's condition has been diagnosed as "chronic schizophrenia" or "paranoid state" does not advise the jury whether hospitalization is necessary. Neither does an opinion that a person is "potentially dangerous," without more, warrant confinement, if that person has never done violence to himself or anyone else. Unless opinions such as these are supported by statements of the behavior on which they are based, the court does not have sufficient information to make a proper legal determination of whether the potential harm is great enough to justify depriving the person of his liberty.

Moss v. State, 539 S.W.2d 549–50 (Tex. Civ. App.—Dallas 1976, no writ).

If appellate judges review mental health cases with the attitude reflected in the language used by the Texas court, appellate review is likely to become an effective vehicle for remedying specific improper commitments and for providing supervision of the commitment process as a system. The mechanical barriers can be overcome. Appeals of this sort can be expedited and the time required to prepare the papers shortened. Appellate courts can be urged to ignore the fact of a patient's release, on the ground that the commitment still imposes a stigma on the former patient and has collateral consequences such as reducing employment opportunities. There is every reason to believe that lawyers performing as effective advocates will soon—where they have not yet—make long strides towards making the appeal process a meaningful part of mental health litigation.

## *Conclusion*

Stimulated by judicial demands and critical reexamination of traditional professional standards, lawyers representing proposed patients in mental health proceedings are tending to redefine their role, which has traditionally been primarily one of guardianship of the client. An ultimate duty to serve as advocate of the wishes of the proposed patient is being recognized, although this realization should supplement rather than replace the obligation to advise and counsel the client as to the wisdom of resisting treatment. While lawyers redefining their role continue to regard courtroom advocacy as an important part of the services they can provide, they are also recognizing the need to negotiate informally for their clients during the prehearing stages of a proceeding. Considerable barriers still preclude widespread acceptance of this advocate-negotiator role, and it is far from universally accepted.

Those lawyers who do accept this role, however, find that mental health litigation provides numerous opportunities to implement that function. Participation in the prehearing stage permits informal negotiation for dismissal of the proceedings, settlement on some form of mutually agreeable treatment or assistance, and preparation for eventual litigation. If the case reaches the hearing stage, numerous developing and well-established procedural rights can be asserted. In addition, recent efforts to develop empirical information concerning the accuracy of diagnoses, treatment prognoses, and behavior prediction provide material that can sometimes be used effectively to challenge or refute expert testimony offered in court. Finally, the process of appeal to a higher court is becoming a meaningful one, and this choice opens upon another forum in which a hitherto unsuccessful advocate can pursue the interests of his client.

Utilization of these opportunities by defense counsel is unquestionably an irritation to many mental health personnel and a major barrier to useful interdisciplinary communication. In large part, this is because many of the pervasive changes that have occurred in the delivery of nonvoluntary mental health care in the last decade become of practical significance to mental health personnel only when asserted by such lawyers on behalf of specific proposed patients.

Underlying much of the disagreement between the new activist lawyers and mental health personnel is a basic difference in philosophical perspective.

Relying largely upon assumptions concerning the value to be given individual choice, the activist lawyers are attempting to develop a system that will subject to programs of nonvoluntary care and treatment only a small subgroup of those who would in fact benefit from such treatment. Insofar as they are successful, they interfere with traditional notions of delivery of mental health care in a manner that is directly disruptive to mental health programs based on different assumptions.

Undoubtedly there will have to be accommodation in the future. Although there are many unsettled legal issues in the mental health field, there can be little doubt that the adversary process will continue to be the model on which mental health litigation must be conducted. On the other hand, the constitutional necessity and general wisdom of narrow criteria for involuntary treatment are subject to greater doubt. The discomfort which many lawyers experience in implementing these narrow standards indicates that further discussion of appropriate criteria is probably the most fruitful area of future interdisciplinary discussion. If lawyers and mental health professionals can arrive at a mutually acceptable criterion for involuntary treatment, implementing that criterion by means of a vigorous adversary system is likely to be much less distressing to mental health personnel than the present situation.

BIBLIOGRAPHY


- Andalman, E. and Chambers, D. L., "Effective Counsel for Persons Facing Civil Commitment: A Survey, A Polemic, and A Proposal," Mississippi Law Journal, 45 (1974), 43.
- Blinick, M., "Mental Disability, Legal Ethics, and Professional Responsibility," Albany Law Review, 33 (1968), 92.
- Chernoff, P. A. and Schaffer, W. G., "Defending the Mentally Ill: Ethical Quicksand," American Criminal Law Review, 10 (1972), 505.
- Cohen, F., "The Function of the Attorney and the Commitment of the Mentally Ill," Texas Law Review, 44 (1966), 424.
- Dix, G. E., "The Role of the Lawyer in Proceedings Under the Texas Mental Health Code," Texas Bar Journal, 39 (1976), 982.
- Goode, S. J., "The Role of Counsel in the Civil Commitment Process: A Theoretical Framework," Yale Law Journal, 84 (1975), 1540.
- Litwick, T. R., "The Role of Counsel in Civil Commitment Proceedings: Emerging Problems," California Law Review, 62 (1974), 816.
- Rock, R., Jacobson M. and Janopaul, R., "Hospitalization and Discharge of the Mentally Ill," University of Chicago Press, Chicago, 1968.
- Stone, A. A., "Lawyers in the Mental Health System," in Mental Health and Law: A System in Transition, National Institute of Mental Health, Rockville, Maryland, 1975.
- "The New York Mental Health Information Service: A New Approach to Hospitalization of the Mentally Ill," Columbia Law Review, 67 (1967), 672.
- Wegner, D. L. and Fletcher, C. R., "The Effect of Legal Counsel on Admissions to A State Mental Hospital: A Confrontation of Professions," Journal of Health and Social Behavior, 10 (1969), 66.

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