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Involuntary Commitment of the Mentally Disabled: Implementation of the Law in Winston-Salem, North Carolina

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INVOLUNTARY COMMITMENT OF THE MENTALLY DISABLED: IMPLEMENTATION OF THE LAW IN WINSTON-SALEM, NORTH CAROLINA

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I. INTRODUCTION

Laws exist in every state allowing for the involuntary psychiatric hospitalization of persons believed to suffer from mental disorder.[1] These laws are grounded in the state's *parens patriae* power, to care for persons who are unable to care for themselves, and its "police power," to protect the public safety and welfare.[2]

In most states prior to the 1960's, "involuntary civil commitment" was largely a medical phenomenon. Anyone deemed by a physician to be "in need of treatment" ordinarily was subject to commitment; and court involvement, where provided for, typically amounted to little more than an "administrative monitoring, often cursory, of a medically oriented process upon which jural apparatus ha[d] been grafted."[3] In the last twenty years, however, this "medical" approach to commitment decision-making has given way to a more legalistic, due process oriented approach. Pointing to the "massive curtailment of liberty" that involuntary commitment entails, lawmakers throughout the country have tightened commitment standards and accorded prospective patients an array of procedural rights and protections.[4] Some observers contend that this "legalization" of the civil commitment process has gone too far—that in many areas of the country it has become unreasonably difficult to ensure that even seriously disordered persons receive the treatment they need.[5] Others suggest that, despite these changes in the law, civil commitment practices have changed very little over the years and persons who threaten neither themselves nor others continue to be hospitalized as before.[6]

In the interest of assessing the degree to which civil commitment practices reflect civil commitment laws, and, moreover, to identify ways in which civil commitment systems might function more effectively, the Institute on Mental Disability and the Law of the National Center for

1. In many jurisdictions, including North Carolina, involuntary outpatient treatment is possible as well. *See generally Practice Manual: State Laws Governing Civil Commitment*, 3 MENTAL DISABILITY L. REP. 205, 205-14 (1979).

2. *See Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1207-23 (1974).

3. R. ROCK, M. JACOBSON & R. JANOPAUL, HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL 259 (1968).

4. *See* Zimmerman & Fitch, *Involuntary Civil Commitment: The Discerning Eye of the Law*, 5 STATE CT. J. 5 (1981).

5. *See* Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 497 (1976).

6. *See* Warren, *Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act*, 11 LAW & SOC'Y REV. 629 (1977); Peters, Teply, Wunsch & Zimmerman, *Administrative Civil Commitment: The Ins and Outs of the Nebraska System*, 9 CREIGHTON L. REV. 266 (1975); Markell & Hiday, *Standards of Dangerousness: Impact of Civil Commitment* (unpublished manuscript) (available from Dr. Virginia Hiday of the Sociology Department at North Carolina State University).

State Courts in 1981 embarked on a multi-year study of civil commitment practices and procedures throughout the country.[7] Winston-Salem, North Carolina was one of six cities in which empirical research was conducted.[8] This article presents the findings of the research conducted in Winston-Salem.[9] It consists of a descriptive analysis of the city's civil commitment system,[10] with reference to North Carolina law,[11] and recommendations for improvement. The descriptive information is drawn primarily from interviews conducted by the research staff[12] with representatives of the legal and mental health communities in Winston-Salem.[13] The recommendations reflect the observations and opinions of the persons interviewed as well as those of the research staff and their advisors.[14]

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7. The first phase of the study, conducted January 1, 1981-June 30, 1982, was supported by grants from the John D. and Catherine T. MacArthur Foundation of Chicago and a consortium of community foundations, including the Winston-Salem Foundation of Winston-Salem, North Carolina. On-going research is funded by the MacArthur Foundation and the Aetna Life & Casualty Foundation.

8. In addition to Winston-Salem, research was conducted in New York, Los Angeles, Chicago, Milwaukee, and Columbus, Ohio. *See* W. FITCH, INVOLUNTARY CIVIL COMMITMENT IN WINSTON-SALEM (1982); W. FITCH, B. MCGRAW, J. HENDRYX & T. MARVELL, INVOLUNTARY CIVIL COMMITMENT IN THE FIRST JUDICIAL DISTRICT, NEW YORK CITY (1982); I. KEILITZ, W. FITCH & B. MCGRAW, INVOLUNTARY CIVIL COMMITMENT IN LOS ANGELES COUNTY (1982); J. ZIMMERMAN, INVOLUNTARY CIVIL COMMITMENT IN CHICAGO (1982); I. KEILITZ & B. MCGRAW, AN EVALUATION OF INVOLUNTARY CIVIL COMMITMENT IN MILWAUKEE COUNTY (1983); I. KEILITZ, INVOLUNTARY CIVIL COMMITMENT IN COLUMBUS, OHIO (1982). These monographs are available at the National Center for State Courts in Williamsburg, Virginia. This research provided the basis for the development of national-scope guidelines for civil commitment. *See* INSTITUTE ON MENTAL DISABILITY AND THE LAW, PROVISIONAL SUBSTANTIVE AND PROCEDURAL GUIDELINES FOR INVOLUNTARY CIVIL COMMITMENT (1982) [hereinafter cited as PROVISIONAL SUBSTANTIVE GUIDELINES].

9. The research in Winston-Salem was conducted in 1981 and 1982, and the findings reported in this article date from those years. The North Carolina statutes pertaining to outpatient commitment were substantially revised in 1983 (effective January 1984). *See* Act of June 29, 1983, ch. 638, 1983 N.C. Adv. Legis. Serv. 104 (codified at N.C. GEN. STAT. §§ 122-58.1 to .13 (Cum. Supp. 1983)). It is reasonable to expect that outpatient commitment practices in Winston-Salem will vary somewhat from those described herein. Because the focus of this article is on commitment practices rather than commitment laws, however, much of what is reported here will remain unaffected by statutory change.

10. The focus of this article is on procedures for the civil commitment of mentally ill persons in Winston-Salem. The article is not intended to apply to the commitment of juveniles, the mentally retarded (except those whose retardation is accompanied by a behavior disorder that renders them dangerous), the developmentally disabled, or persons charged with, convicted of, or acquitted by reason of insanity of a criminal offense.

11. N.C. GEN. STAT. §§ 122-1 to -122 (1981). *See supra* note 9.

12. The research staff consisted of Joel Zimmerman, Ph.D.; Ingo Keilitz, Ph.D.; Janice Hendryx, M.A.; and the author. Valuable assistance was provided by Paul Barnett and Doug Shoppert, law students at the Marshall-Wythe School of Law, College of William and Mary.

13. Interviews were conducted with judges, court clerks, attorneys, psychiatrists, psychologists, social workers, hospital administrative personnel, law enforcement officers, former patients, families of patients, and state agency representatives.

14. During the course of the study, the research staff were counseled by a board of advisors consisting of Paul Appelbaum, University of Pittsburg; Paul Friedman, Ennis, Friedman, Bersoff, and Ewing; B. James George, Jr., New York Law School; Richard P. Lynch, American Bar Asso-

II. THE PREHEARING PROCESS

This section considers the events in the involuntary commitment process that take place prior to a court hearing. Many cases are disposed of in the prehearing stage. Respondents[15] in some cases are screened out by the clerk who reviews the allegations of the petitioner or by the physician who conducts the initial evaluation; in other cases they may be hospitalized for evaluation and observation but be discharged before the hearing is held. Some respondents become voluntary patients during the prehearing period, obviating the need for further judicial involvement.

The manner in which commitment cases are handled prior to hearing may have more bearing on the overall "success" of a commitment system than what happens at any other stage in the commitment process. Systems that provide for an effective, community-based screening and diversion of inappropriate cases protect both the liberty interests of the respondent and the fiscal interests of the state.

A. *Description*

1. Initiating the Commitment

Anyone in North Carolina may petition for the commitment of another who is considered to be mentally ill or inebriate and dangerous to self or others, *or* mentally retarded and, because of an accompanying behavior disorder, dangerous to others.[16] The petitioner ordinarily must appear before a clerk of the superior court or a magistrate of the district court and execute an affidavit concerning the proposed patient's mental condition.[17] If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in the affidavit are true and that the respondent probably meets the criteria for commitment, he or she may order the respondent taken into custody by a law enforcement officer for examination by a qualified physician.[18]

In Winston-Salem, the assistant clerk of the superior court receives petitions for involuntary commitment at the courthouse during regular business hours. Three magistrates receive petitions on a shift basis at

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ciation; Floyd E. Propst, Fulton County (Georgia) Probate Court; Loren H. Roth, University of Pittsburg; Joseph Schneider (chairperson), Cook County (Illinois) Circuit Court; David B. Wexler, University of Arizona; and Helen Wright, National Association for Mental Health. In addition, researchers in Winston-Salem received guidance from a local advisory board chaired by Gary P. Tash, Judge of the District Court serving Winston-Salem.

15. Prospective involuntary patients are referred to as respondents throughout this article.

16. N.C. GEN. STAT. § 122-58.3(a) (1981).

17. *Id.* Affiants who are qualified physicians may execute the oath to the affidavit before any official authorized to administer oaths. They are not required to appear before the clerk or magistrate for this purpose. *Id.* § 122-58.3(d).

18. *Id.* § 122-58.3(b).

their residences during the evening hours and on weekends.[19] A prospective petitioner may initiate a proceeding by telephoning the clerk and explaining why he or she believes that someone needs to be committed. If commitment clearly is not indicated, the clerk may refer the caller to other assistance.[20] If the caller's allegations provide reasonable grounds to believe that the person meets the commitment criteria, the clerk will invite the caller to appear in person for the purpose of submitting a petition for commitment.

When the petitioner appears, the clerk explains the commitment procedure and again considers the petitioner's reasons for pursuing a commitment. If it appears that the proposed patient would not meet the criteria for commitment, the clerk may suggest that the petitioner seek help for the person in some way other than by involuntary commitment. If the petitioner's allegations would support a commitment, the clerk types out a petition/affidavit and has the petitioner sign and give an oath. Then the clerk issues an order for the respondent's custody, schedules a hearing, and issues notices of the hearing to be served on the respondent and the petitioner. Finally, the clerk completes a form entitled "instructions for service of involuntary commitment papers," advising the law enforcement officer where the respondent is to be taken for examination. Before completing this form, the clerk provides the petitioner with an opportunity to arrange for commitment to a private facility, if desired.

Under particular "emergency circumstances,"[21] a law enforcement officer may take someone into custody and bring him or her immediately before a magistrate or a clerk without a prior order. In such cases, the law enforcement officer must execute the affidavit and swear to the emergency circumstances. If the clerk or magistrate finds by clear, cogent, and convincing evidence that the facts stated in the affidavit are true and that emergency circumstances exist, he or she may order the person taken directly to a community or regional mental health facility for inpatient custody and observation pending a court hearing.[22]

As a matter of practice in Winston-Salem, persons taken into custody pursuant to the emergency procedure ordinarily are not brought before a clerk or a magistrate before they are hospitalized. Rather, law enforcement officers typically take such persons directly to a mental

19. Throughout this article, unless otherwise noted, references to the clerk are intended to apply to the magistrates as well.

20. Cases involving alcohol or drug abuse routinely are diverted.

21. Emergency circumstances exist when a person subject to detention under the statute "is also violent and requires restraint, and delay in taking him or her to a qualified physician for examination would likely endanger life or property." N.C. GEN. STAT. § 122-58.18 (1981).

22. *Id.* § 122-58.18.

health facility and arrange for detention there, either by another officer or by the facility staff, while they appear before the clerk to petition for the commitment and arrange for the necessary papers.

By all reports, the assistant clerk of the superior court in Winston-Salem is readily accessible to petitioners and the police during regular working hours. The district court magistrates reportedly are not so accessible, however. Each of the magistrates is said to reside outside of the city limits, necessitating a drive of twenty to thirty minutes each way for petitioners and the police. Furthermore, while the assistant clerk of the court is known for carefully reviewing the facts before issuing a petition, the magistrates are said to vary considerably in the quality of review they provide.

2. Taking Custody of the Respondent

Within twenty-four hours after a custody order is signed, a law enforcement officer must take the respondent into custody. Immediately upon assuming custody and, in any event, within forty-eight hours, the officer must take the respondent to a community mental health center for examination by a qualified physician. If no qualified physician is available at the community mental health center, the officer may take the respondent to any qualified physician who is available locally. If no qualified physician is immediately available in the locality, the officer may temporarily detain the respondent in a community mental health facility, if one is available. If none is available, the officer may arrange for detention of the respondent, under appropriate supervision, in the respondent's home, in a private hospital or clinic, in a general hospital, or in a regional mental health facility, but not in a jail or other penal facility.[23] If the affiant who obtained the custody order is a qualified physician,[24] or if the respondent was taken into custody pursuant to the emergency procedure described above,[25] the community-based examination requirement does not apply and the law enforcement officer may take the respondent directly to a mental health facility for custody and observation pending a hearing.

If the respondent is a female, she must be accompanied to the hospital by a member of her family, if a family member is available; otherwise, she must be accompanied by a female designated by the director of social services of the county of the female's residence or the county of admission.[26] The statutes authorize the officer issuing the custody order under certain circumstances to permit the respondent's family or

23. *Id.* § 122-58.4(a).
24. *Id.* § 122-58.4(b).
25. *Id.* § 122-58.18.
26. *Id.* § 122-49.

immediate friends to transport the respondent to the hospital if they wish.[27]

Whenever feasible, law enforcement officers transporting respondents are to dress in plain clothes and use unmarked vehicles.[28] Officers may use reasonable force to restrain respondents if necessary to protect themselves, respondents, or others, and may not be held criminally or civilly liable for assault, false imprisonment, or other torts or crimes for "reasonable measures taken under the authority of this Article."[29]

In Winston-Salem, a special, three-officer, plain-clothes unit of the city police department is responsible for the transportation of respondents during business hours. These officers execute custody orders issued by the clerk and transport respondents to court on the hearing day each week. Uniformed officers typically are involved in emergency cases and in cases arising when the officers of the special unit are unavailable.[30]

The Winston-Salem police reportedly do not ordinarily arrange to have a family member or designated female accompany an officer engaged in the transportation of a female respondent. However, to discourage police misconduct and at the same time create a record to protect the police department against charges of improper conduct during the period of transportation, the police have a procedure of recording the time of day and the police car's odometer reading when a female respondent is taken into custody and again when the police car arrives at its destination. The presumption is that no improper conduct has occurred if the recorded time and distance are compatible.

Although the custody order issued by the clerk ordinarily permits the officer to deliver the respondent to any approved treatment facility,[31] the "instructions for service of involuntary commitment papers" are specific with regard to delivery of the respondent, designating a single receiving facility. Police officers in Winston-Salem believe that they have no authority to take the respondent to any facility other than the one designated in the instructions. If the designated facility refuses to receive a respondent ordered for evaluation (which sometimes happens when all of the facility's beds are occupied), police officers believe they must release the respondent. Representatives of the court, however, maintain that officers are not so constrained by the clerk's instructions and may deliver respondents who are refused at one facility to any

27. *Id.* § 122-58.14(d).

28. *Id.* § 122-58.14(b).

29. *Id.* § 122-58.14(c).

30. Respondents from counties served by the Winston-Salem courts are transported by law enforcement officers from the counties' sheriff's departments.

31. This was revealed by an examination of several orders.

other approved facility for examination.[32]

In Winston-Salem, the facility to which the respondent is taken initially typically is the one in which he or she will be detained pending the hearing. This variation from the statutory provision contemplating outpatient evaluation at a community mental health center and prehearing detention in another facility is made possible by the availability of in-patient facilities to serve both functions in Winston-Salem.

The mental health facilities in Winston-Salem have varying policies with regard to the respondent's custody before and during the initial examination. At the local public facility, the officer must wait with the patient until the examining physician arrives and completes the examination.[33] At the private facilities, the officers are permitted to leave the respondent in the facility's custody until the physician arrives to conduct the examination. It was suggested that the private facilities agree to take custody because respondents destined for these facilities tend to be less aggressive and difficult to hold and because it may take significantly longer, particularly during off-hours, for physicians to become available to conduct examinations at the private facilities.

Police officers in Winston-Salem report that they occasionally will notify a hospital in advance that a respondent is being brought in, but the hospitals rarely will call an examining physician until after the officer has arrived at the facility with the respondent and the appropriate papers from the court. A spokesperson at one facility explained that physicians are not called sooner because the custody-taking sometimes is delayed and the respondent may not arrive until several hours after the officer's call.

3. Screening the Respondent (The Initial Examination)

Respondents taken into custody must be examined by a qualified physician as soon as possible and, in any event, within twenty-four hours after presentation for examination at a mental health facility.[34] If the examining physician believes that the respondent meets the statutory criteria for commitment, the respondent may be taken to a community or regional mental health facility for temporary custody, observation, and treatment pending the hearing. If the physician be-

32. Of course, respondents examined at one facility and found not to meet the commitment criteria may not be delivered to a second facility for further evaluation.

33. It was reported that during business hours an officer usually must wait approximately thirty minutes for a physician to arrive to conduct the examination. The wait may be as long as two hours. During off-hours, when physicians are on call, the wait reportedly is a minimum of sixty minutes.

34. N.C. GEN. STAT. § 122-58.4(c) (1981). As noted earlier, this initial evaluation is not required if the affiant was a qualified physician or if the respondent was taken into custody pursuant to the emergency procedure. *See supra* note 17.

lieves that the respondent does not meet the commitment criteria, the respondent must be released and the proceedings must be terminated. The findings of the physician and the facts on which they are based must be put in writing and be transmitted to the clerk of the superior court. If the clerk is unlikely to receive the physician's report within forty-eight hours after it was signed, the physician also must communicate his or her findings to the clerk by telephone.[35]

The statute clearly contemplates that the initial medical examination will function essentially as an outpatient, community-based screening of the respondent to determine whether the commitment proceeding should continue. In Winston-Salem, because this initial examination is conducted at the same facility in which the respondent may be detained pending a hearing, the results of the examination typically are used to determine the respondent's treatment needs as well as whether the proceeding should continue.

In Winston-Salem the initial examination is said always to be conducted within twenty-four hours of the respondent's presentation at the facility. After the examination, the physician completes a court form indicating his or her findings and presents the form to the police officer for delivery to the court. If the police officer is unavailable, the physician mails the form to the court.

4. Prehearing Detention

If the physician conducting the initial evaluation of the respondent believes that the respondent is committable, the respondent is transported to a community mental health facility or some other public or private facility for temporary custody, observation, and treatment pending a court hearing. If no community mental health facility is available and the respondent is unable to pay for his or her care at a private facility, the law enforcement officer may take the respondent to a regional psychiatric facility.[36]

Because Winston-Salem has a number of local, inpatient facilities that are available to conduct initial evaluations and function as prehearing detention facilities as well, respondents ordinarily need not be moved following the initial evaluation. Respondents awaiting hearing in Winston-Salem typically are detained in one of three local facilities: Forsyth-Stokes Community Mental Health Center, a public community mental health center; Forsyth Memorial Hospital, a private facility; or Mandala Center, also a private facility. If the respondent is particularly violent, he or she may be detained at the John Umstead Hospital in Butner (one of four regional psychiatric facilities in North

35. *Id.* § 122-58.4(c)-(d).
36. *Id.* § 122-58.4(c).

Carolina). Reportedly, respondents are seldom transferred from one facility to another during the prehearing period unless a medical emergency requires transfer to a general services hospital.

Contemplating removal of the respondent to a detaining facility following an initial evaluation elsewhere, the law provides that, within twenty-four hours of arrival at the detaining facility, the respondent must be examined by a qualified physician.[37] If the physician conducting this examination believes that the respondent does not meet the commitment criteria, he or she must release the respondent pending the court hearing and notify the clerk who issued the custody order.[38] Despite this release requirement, physicians in the hospitals in Winston-Salem report that they frequently retain respondents until their hearings regardless of the results of this examination. More discussion of this subject will appear in the section on Prehearing Discharge.

The maximum time allowed by statute for prehearing detention is ten days, unless a continuance is ordered.[39] It was reported that hearings are conducted reliably within the statutory period in Winston-Salem.

Although the law provides for notice to the respondent, the petitioner, and the respondent's counsel of the time and place of the hearing, there is no requirement that notification of the respondent's detention be given to anyone. The policies of the local facilities vary with regard to notice. The staff of one facility reported that, if the respondent is brought in by a police officer, every effort is made to notify members of the respondent's family. Staff at another facility stated that, although there is no official notification policy, family members usually are involved in the respondent's treatment. The policy at the third local facility is not to release information about patients without their consent.

5. Prehearing Examination

The law provides that a respondent must be examined by a qualified physician within twenty-four hours of his or her arrival at the facility in which he or she will be detained pending a hearing.[40] The findings of the physician and the facts on which they are based must be put in writing and be transmitted to the clerk of the superior court by "reliable and expeditious means."[41] If the affiant for commitment is a physician, a second qualified physician (who is not treating the patient) must

37. *Id.* § 122-58.6(a). This second examination is described later in this article. *See infra* notes 42-43 and accompanying text.
38. N.C. GEN. STAT. § 122-58.6(a) (1981).
39. *Id.* § 122-58.7(a).
40. *Id.* § 122-58.6(a).
41. *Id.* § 122-58.6(b).

perform the examination at the detaining facility.[42]

Because respondents in Winston-Salem usually are detained prehearing in the same facility in which they were examined initially, the second examination, as a practical matter, is not always conducted within twenty-four hours of admission. The policies of the local facilities vary in this regard. At two of the facilities, the staff were uncertain whether the second examination was to be conducted within twenty-four hours of the respondent's arrival at the facility or within twenty-four hours of the first evaluation. In any event, the staff at both facilities indicated that this requirement usually was not met and that the second evaluation typically was not conducted until about two to four days after the respondent's admission to the facility. At the third facility, second examinations reportedly are conducted three or four days after the initial examination; if there is a significant difference of opinion between the first two examination reports, a third examination is conducted.

No one at any of the facilities in Winston-Salem suggested that respondents were ever advised of a right to remain silent during the examination. However, one facility has a policy to inform everyone admitted as a result of court involvement how the information generated by the examination might be used in court.

Hospital personnel report that respondents in Winston-Salem very rarely request to be examined by an independent physician. When such requests are made, the hospitals reportedly are happy to cooperate. However, the cost of the examination must be borne by the respondent; there is no right in North Carolina to an independent examination at the government's expense.

The facilities in Winston-Salem have differing policies concerning the release or continued detention of respondents found by the examining physician not to meet the criteria for commitment. While some physicians routinely discharge such respondents pending the hearing, others believe that only the judge may order release.[43]

6. Prehearing Treatment

Pending the court hearing, "the qualified physician attending the respondent is authorized to administer reasonable and appropriate . . . medication and treatment that is consistent with accepted medical stan-

42. *Id.* § 122-58.3(d).

43. Recall that a finding of noncommittability at the *initial* examination results in a dismissal of the proceeding; a hearing still must be held if the findings of the physician conducting the *second* examination (the first for respondents detained pursuant to the emergency procedure or upon the affidavit of a qualified physician) show that the respondent does not meet the commitment criteria.

dards."[44] The statutes guarantee patients a right to treatment "including medical care and habilitation, regardless of age, degree of retardation or mental illness."[45] Patients also have a "right to be free from unnecessary or excessive medication with drugs" and from the use of drugs as punishment or discipline.[46] Finally, extraordinary forms of treatment (electroshock therapy, the use of experimental drugs or procedures, and surgery other than emergency surgery) may not be given without the patient's informed written consent.[47]

Medication is reportedly administered to most involuntarily committed patients in Winston-Salem, regardless of their legal status; respondents, more often than not, are under the influence of medication at their hearings. At no facility in Winston-Salem is the respondent advised of any right to refuse treatment. Whether and to what extent such a right is extended to patients who object to treatment varies among the city's treatment facilities. A spokesperson for one of the facilities reported that non-dangerous patients were accorded a right to refuse treatment but dangerous patients were not. He added that only an "indication of potential dangerousness" was necessary; the patient need not have committed an overt, dangerous act. Another person associated with the same facility reported that the policy was to recognize a right to refuse treatment except in circumstances of "imminent danger." This spokesperson indicated a belief that the right to refuse treatment was a matter of statute in North Carolina and that unless a patient were imminently dangerous an adjudication of the patient's incompetency would be necessary before treatment could be forced. It was reported at another facility that the policy concerning treatment refusal followed the "best interests" rationale; the physician would refrain from treating only if it were in the patient's best interests. For example, a physician might consider whether forcing medication would so destroy the rapport between doctor and patient as to create a greater negative effect on the patient's recovery than would the lack of medication. A spokesperson for the third facility reported that the right to refuse treatment was asserted so infrequently that no policy had been formulated. He stated that the rare patient who refused treatment would likely be transferred to another facility.

7. Conversion to Voluntary Status and Retention of Voluntary Patients

The statutes in North Carolina declare that "[i]t is the policy of the

44. N.C. GEN. STAT. § 122-58.6(c) (1981).
45. *Id.* § 122-55.5.
46. *Id.* § 122-55.6.
47. *Id.*

State to encourage voluntary admissions to treatment facilities."[48] "Any person who believes himself or herself to be in need of treatment for mental illness or inebriety may seek voluntary admission to a treatment facility"[49] by completing a written application for admission and presenting himself or herself to the facility for evaluation. The person must acknowledge in the application that he or she may be held by the treatment facility for a period of seventy-two hours subsequent to any request that he or she may make to be released. If the evaluating physician determines that the person is not in need of treatment or further evaluation by the facility or that the person will not benefit from the treatment available, the person will not be accepted as a patient by the facility.[50]

Observers in Winston-Salem voiced differing opinions concerning the frequency with which involuntary patients convert to voluntary status. Everyone agrees that at least some savvy respondents attempt to convert in order to win the right to request their release. Some people in the community have the impression that the local facilities recognize an absolute *right* of involuntary patients to convert to voluntary status and that many such patients were converting and then quickly discharging themselves. Judges in Winston-Salem, however, declare that respondents have no right to convert to voluntary status, only the right to *request* such a conversion, and that committed patients may be converted only with the approval of the treating physician. One judge stated that if a respondent were before him during a hearing and the doctor's recommendation were that the respondent be allowed to become a voluntary patient, he would have no objection unless other facts before the court compelled an involuntary commitment.

Like the judges, physicians in Winston-Salem recognize no right of the respondent to convert to voluntary status, but most admit that they are reluctant to deny a respondent's request to convert. A spokesperson for one of the facilities in Winston-Salem estimated that fifty percent of the commitment cases in which it was involved resulted in a recommendation to the court that the respondent be permitted to remain at the facility on a voluntary basis.

Various perceptions exist in Winston-Salem regarding what is done with dangerous voluntary patients who request discharge. Community representatives and attorneys believe that the facilities routinely grant discharge requests. However, spokespersons for the facilities report that if a voluntary patient requesting release is seriously ill and "really dangerous," the facility physicians either will arrange for a relative of

48. *Id.* § 122-56.1.
49. *Id.* § 122-56.3.
50. *Id.*

the patient to petition for involuntary commitment or, if this is not possible, will submit a petition themselves. A spokesperson for one of the facilities suggested that, in this situation, a physician usually can deter the patient from following through with his or her request for discharge by threatening to bring an involuntary commitment action.

8. Prehearing Discharge

If the qualified physician conducting the initial examination of the respondent believes that the respondent does not meet the commitment criteria, the respondent must be released and the proceedings must be terminated.[51] If the qualified physician conducting the second examination (or the first if pursuant to the emergency procedure or upon a medical affidavit) believes that the respondent does not meet the commitment criteria, the respondent must be released pending the hearing and the clerk of the superior court of the county from which the respondent was sent must be notified.[52] Finally, any involuntarily committed patient in North Carolina who is determined by the chief medical officer of the hospital to be no longer in need of hospitalization must be released.[53]

As a matter of practice in Winston-Salem, respondents ordinarily are released if the qualified physician conducting the initial evaluation determines that the commitment criteria are not met. If the initial examination results in a finding of committability but the physician conducting the second examination believes that the respondent is not committable, the respondent may or may not be discharged. Some observers in Winston-Salem contend that automatic discharge upon a finding of noncommittability by the second examining physician is inappropriate because both examinations are conducted by highly trained psychiatrists at the same facility and a disagreement between such professionals creates a valid question about the committability of the respondent.

A spokesperson at one facility reported that the discharge decision was for the treating physician to make and the physician conducting the initial evaluation ordinarily was the treating physician. According to this spokesperson, if the treating physician's examination resulted in a finding of committability but the second examiner's opinion was that the respondent was not committable, the treating physician might: defer to the opinion of the second examining physician and release the respondent, conduct a re-examination of the respondent, or observe the respondent's progress in the facility for a few days before deciding

51. *Id.* § 122-58.4(c).
52. *Id.* § 122-58.6(a).
53. *Id.* § 122-58.13.

whether to discharge. A spokesperson at one of the other local facilities reported that, regardless of whether the second examining physician believes that the respondent meets the commitment criteria, the respondent always is detained in the facility until the time of the hearing. Reportedly, no one in the community ordinarily is notified when a respondent is discharged prior to the hearing.

B. *Strengths, Weaknesses, and Recommendations for Improvement*

1. Initiating the Commitment

The requirement that any attempt to initiate a commitment be subject to a judicial screening is a strength of the North Carolina commitment procedure. Although some people in Winston-Salem believe that the screening unduly delays the provision of treatment, most agree that its potential for protecting against unwarranted infringement of the respondent's liberty and for saving the cost of unnecessary detention, examination, etc., more than offsets the delay concern.

Many people in Winston-Salem believe that the use of magistrates to screen prospective patients is not effective. Requiring prospective petitioners or the police to travel outside of the limits of the city to the homes of magistrates is viewed by some as a serious weakness in the city's commitment system because it makes initiating a commitment difficult and slow. It is especially problematic for police involved in emergency cases, as the law requires that respondents in emergencies be taken directly before a clerk or magistrate prior to hospitalization.

Recommendation: In order to improve access of prospective petitioners and the police to the magistrates, one or more of the following procedures should be implemented:

- *only magistrates living within the city limits of Winston-Salem should be authorized to receive commitment applications;*
- *a clerk or a magistrate who is authorized to receive commitment applications should be available at the courthouse at all times;*
- *a system should be developed to enable petitions for involuntary commitments to be submitted and approved by telephone.*[54]

54. A telephone commitment application system might be devised to function much like telephone warrant systems that are being used in some states to enable criminal warrants to be obtained by telephone. One possible procedure would be for a prospective petitioner or the police to telephone the magistrate at his or her home and communicate whatever allegations would otherwise be communicated in person. The magistrate would consider the allegations, and, if he or she decided that a petition were in order, would prepare such a petition and read it over the telephone to a law enforcement officer at the police department designated to perform the ministerial function of copying the petition onto an appropriate form, signing the magistrate's name (on the magistrate's authorization), and making the petition available at the police department for the signature of the petitioner or police officer initiating the commitment. The magistrate would deliver a signed written authorization for the petition as soon as possible by mail or otherwise.

The special statutory provision allowing the police to take persons into custody under emergency circumstances is a strong feature of the North Carolina commitment law. It promotes the public's safety and provides for the immediate treatment needs of seriously disordered persons. Further, because it restricts immediate custody-taking to particular emergency situations and conditions detention on a judicial finding by clear, cogent, and convincing evidence that the respondent meets the commitment criteria, it provides a measure of protection for the respondent's liberty interests as well.

Although not in compliance with the requirements of North Carolina law, the practice of the police in Winston-Salem to take respondents detained pursuant to the emergency procedure directly to a treatment facility (rather than before a clerk or magistrate) may be reasonable in some cases. When someone is severely disordered, unusually violent, and otherwise in need of immediate attention, delay in hospitalizing the person may be harmful to the person as well as to the interests of society. The requirement that respondents in emergencies be taken immediately before a magistrate or a clerk appears to have been formulated with the rural areas of North Carolina in mind, to prevent the taking of respondents to facilities outside of their communities without some prior judicial review. Because of the availability of prehearing detention facilities in Winston-Salem, however, no such removal from the community ordinarily is necessary.

Recommendation: A statutory amendment should be sought authorizing a law enforcement officer to transport a respondent directly to the closest mental health facility in an emergency.[55]

The practices of the clerk's office in the initiation of commitment proceedings complement the statutory provisions and result in a satisfactory initiation procedure in Winston-Salem. The policy of the clerk to explain the civil commitment procedure to petitioners is applauded by many people in Winston-Salem. The opportunity provided to the petitioner to arrange for commitment to a private facility also is recognized as a strong feature because it makes commitment more palatable to some petitioners. The forms developed and used by the clerk's office for recording allegations, instructing officers concerning the service of

55. The amendment might be drafted in such a way that the law enforcement officer's authority would be conditional. For example, in order to minimize the intrusion on the respondent's liberty, the authorization might be made applicable only when a facility is located near the place where the respondent was taken into custody (e.g., within twenty-five miles); and the provision might require the release of the respondent from the facility if, within a given amount of time following detention (e.g., two and one-half hours), no properly executed custody order is received by the facility.

commitment papers, etc., seem to be well-designed to capture and convey important information.

Despite the overall reasonableness of the commitment initiation procedures in Winston-Salem, many people in both the mental health and the legal communities in the city believe that petitions too often are approved for persons who clearly do not meet the commitment criteria. Some believe that the magistrates almost never deny a petition request. Observing that "petitioners often exaggerate allegations in order to persuade the clerk to approve the petition," one psychiatrist suggested that very few respondents sent for evaluation truly are dangerous to themselves or others. Of course, the burden of proof applicable in the clerk's screening is relatively low; therefore, it should not be very surprising that many questionable cases survive this review, particularly cases arising during the hours when magistrates are on call (since these are more likely to involve respondents whose needs are dire). To the extent that inappropriate cases are processed through the system, respondents suffer an unnecessary deprivation of liberty and society suffers an unnecessary expense.

Recommendation: The clerk and the magistrates should review carefully the allegations of petitioners before approving petitions and issuing custody orders.

2. Taking Custody of the Respondent

The law in North Carolina and the practice in Winston-Salem regarding the transportation of respondents in civil commitment proceedings are generally commendable. The use of unmarked cars and plainclothes police protects the privacy interests of the respondent and may be psychologically less traumatic as well. The conditions under which the police may take someone into custody without prior judicial approval provide a reasonable protection against unwarranted police action and yet allow for immediate attention to cases presenting true emergencies.

The failure of the police department in Winston-Salem to comply with the statutory requirement that a member of the respondent's family or a female designated by the county accompany the police officer engaged in the transportation of a female respondent does not seem to be a matter of particular concern to anyone in Winston-Salem. Moreover, the department's special procedure of recording the time of day and odometer reading when a respondent is taken into custody and comparing this with the time of the respondent's delivery and the odometer reading at that point provides a measure of protection against possible mishandling of the respondent during the period of

transportation. Nevertheless, the police should recognize that their operating policy is not in compliance with statute and that, as a result, an officer accused of misconduct may find it more difficult to claim immunity from liability.

The occasional practice of law enforcement officers in Winston-Salem to notify a facility in advance when a detention is anticipated is an excellent method for expediting the screening and evaluation process, particularly during the evening hours and on weekends, when physicians are on call. The reluctance of the local facilities to call a physician prior to the respondent's arrival at the facility negates the possible benefits of this notification. Of course, such reluctance is understandable if the delivery of promised respondents very often is delayed.

Recommendation: Whenever practical, particularly during the evening hours and on weekends, any law enforcement officer responsible for transporting a respondent to a mental health facility for evaluation should telephone the facility in advance and alert personnel of the facility that a respondent is to be delivered for evaluation. Such a call should be made only after the officer is reasonably certain that the respondent will be taken into custody without delay. Upon receiving such a call, the facility personnel immediately should make the necessary arrangements for a qualified physician to be available to evaluate the respondent as soon after the respondent's arrival as possible. If the custody-taking is delayed, the officer immediately should telephone the facility and report the delay.

The procedure that is followed in at least one of the local mental health facilities, whereby the law enforcement officer must wait with the respondent at the facility until the examining physician has completed the examination, has strong and weak features. One strength is that the officer's presence during the examination makes it possible for the examining physician to question the officer about the circumstances under which the respondent was taken into custody. It enables the officer promptly to return the respondent to his or her home should he or she be found not to meet the commitment criteria. A weakness, however, is that the officer often must be idle for an hour or more, waiting for a qualified physician to become available to conduct the examination. In an effort to balance these interests, the following recommendation is made.

Recommendation: The officer taking the respondent to the mental health facility for evaluation ordinarily should remain at the facility, if possible, until the physician has completed his or her evaluation and made a committability determination. However, if it is foreseen that no physician will be available to begin the evaluation within a reasonable period of time following the officer's arrival at the facility, the officer should be free to

leave the respondent in the custody of the facility. In any event, the officer (or another officer) should be available on short notice to return the respondent to his or her home or other place should the physician find that the respondent does not meet the commitment criteria.

The practice of the Winston-Salem police to release respondents refused for evaluation by the facility designated on the officer's "instructions for service of involuntary commitment papers" is a matter of great concern to some people in the city. These people contend that because respondents ordered for evaluation already have been determined "probably" to meet the commitment criteria, release should not occur before evaluation if *any* local facility is available to conduct an evaluation. Representatives of the court agree and dismiss this issue as a misunderstanding on the part of the local law enforcement officers. They point out that the facility named in the instructions simply is the facility to which the respondent should be delivered first and that nothing in the instructions is intended to prevent a law enforcement officer from taking a respondent refused for evaluation at one facility to another approved facility for evaluation.

Recommendation: The clerk should indicate clearly on the "instructions for service of involuntary commitment papers" that the officer may deliver the respondent to another approved facility for evaluation if the initial facility to which the law enforcement officer is instructed to deliver the respondent refuses to receive the respondent for evaluation.

3. Screening the Respondent (The Initial Examination)

The statutory provision for a medical screening in the community prior to hospitalization is a strong feature of the commitment procedure in North Carolina. It is especially important for respondents residing in rural areas, as it protects against their removal from the community until such removal (for care and custody at a regional facility pending a hearing) is determined to be medically necessary. The provision arguably is not as important in Winston-Salem, however, because the facilities in which respondents in Winston-Salem usually are detained prior to prehearing are located in the city.

The exception to the requirement for an initial community screening in emergency cases is necessary to expedite the detention and treatment of persons whose needs require immediate attention. The absence of the liberty protection provided by the community-based screening is balanced somewhat by the higher burden of proof (clear, cogent, and convincing) that must be met in the clerk's or magistrate's screening of allegations in emergency cases.

One possible weakness in North Carolina's commitment law and in

the practice in Winston-Salem concerns the lack of notification given to the respondent concerning the manner in which information generated by the evaluation might be used by the court. Additional discussion of this issue appears later, in the Prehearing Examination section.

4. Prehearing Detention

A strong feature of the North Carolina law governing prehearing detention is that it restricts detention exclusively to mental health facilities. Furthermore, it permits detention in one of the state's regional psychiatric facilities only if no public mental health facility is available in the community and private commitment is not feasible. People in Winston-Salem agree that detention in any of the city's community facilities is preferable, from a therapeutic standpoint, to detention in the regional facility at Butner.

A possible weakness in the prehearing detention law in North Carolina is its failure to provide for the release of respondents into the community during the prehearing period.[56] Given that only persons who are alleged to be dangerous to themselves or others are subject to commitment, however, it is unlikely that prehearing release often would be appropriate. Indeed, research in states whose laws permit prehearing release reveals that, in practice, respondents very rarely are released pending their hearings.[57]

A number of people in Winston-Salem believe that ten days is too long for respondents to be detained without judicial review. In some states, a preliminary probable cause hearing must be held within a number of hours of detention, followed by a full hearing thereafter. Research has shown that such an arrangement is not always satisfactory, however.[58] Probable cause hearings add greatly to the cost of commitment, and the low burden of proof required at probable cause hearings usually is met in all but the most blatantly abusive cases (which should be detectable by a less formal, and less costly, screening procedure). Requiring the full hearing to be held sooner than ten days following detention would pose significant logistical difficulties in Winston-Salem. Were it not for a generally excellent screening by the clerk's review of allegations and the initial medical examination, a quicker judicial review might be needed.

The law in North Carolina is weak and the practice in Winston-Salem is inconsistent with respect to the provision of notice concerning a respondent's detention. The statute does require that the examining

56. Respondents found by a qualified physician not to meet the criteria for commitment must be released pending the hearing. N.C. GEN. STAT. § 122-58.6(a) (1981).

57. J. ZIMMERMAN, *supra* note 8, at 38.

58. I. KEILITZ, *supra* note 8, at 74.

physician notify the court clerk of his or her findings (and, in effect, of the respondent's detention), and the clerk, after receiving such notice, must assign counsel and notify counsel, the respondent, and the petitioner of the time and date of the hearing. There is no requirement, however, that anyone else be notified of the respondent's status or that the hospitals or the court refrain from notifying particular individuals whom the respondent indicates he or she would prefer not be notified. Although the question of notice might be considered moot because petitioners are usually members of the respondent's family and are free to inform whom they wish, a notification policy should be developed, if only for those cases in which petitioners are not family. Whether the respondent should be permitted to prevent notification of particular persons is a difficult question, particularly if the respondent's competency to make such a decision is questionable. However, most observers agree that the respondent's wishes in this regard should be respected.

Recommendation: It should be the responsibility of staff of the facility in which the respondent is to be detained pending a commitment hearing to inform the respondent of his or her right to have family members or others notified of the detention. Staff should explain to the respondent that, unless he or she objects, the next of kin will be notified of the detention. If the respondent expresses a desire to restrict notifications of his or her detention, the facility should respect this and refrain from notifying anyone other than those required by law to receive notification of the detention.

5. Prehearing Examination

The time constraints imposed by law on prehearing examinations present a problem for many people in Winston-Salem. Most observers believe that the statute was designed for the state's rural areas, where the two required examinations are conducted in different facilities. In Winston-Salem, where both examinations are conducted in the same facility, it ordinarily should not be necessary for both examinations to be conducted within twenty-four hours of the respondent's arrival at the facility.

Of greater concern in Winston-Salem is the failure of the law to require any examination after the first day or two in the respondent's period of detention. It is important that an examination be conducted near the time of the hearing so that the court will have current information about the respondent's condition. Thus, some local physicians delay the second examination until nearer the time of the hearing; others conduct the second examination during the first few days of the respondent's detention (but not necessarily within twenty-four hours of the

first evaluation) and conduct a third examination shortly before the time of the hearing. Because the second examination may be intended to function as a check on the findings of the first examiner, delaying the second examination may jeopardize the respondent's chances for an early release. Requiring that a third examination be conducted may increase the cost of the commitment process, but many believe that, given the court's need for current information, the cost of a third examination is justified.

Recommendation: Regardless of how many examinations are required, the respondent should be examined shortly before the commitment hearing, and the results of such examination should be made available to the court at the hearing.

There is no requirement in North Carolina that the mental health examiner have any mental health training or experience. As a practical matter, however, the physicians who conduct evaluations at the facilities in Winston-Salem and at the John Umstead Hospital in Butner are psychiatrists. Because of this and because it is unclear whether sufficient numbers of physicians with training and experience in mental health are available in other areas of the state, it would be premature to recommend that the statute be amended to require that evaluations be conducted only by such physicians. People in Winston-Salem should be sensitive to the fact that not all physicians have meaningful mental health training or experience, however, and should insist that evaluations continue to be conducted only by psychiatrists.

In a number of states, respondents in involuntary civil commitment proceedings have a right to remain silent during the mental health evaluation. It has been held, however, that the privilege against self-incrimination in North Carolina does not apply to involuntary commitment proceedings to preclude the use of statements by the respondent to the mental health examiner.[59] Nevertheless, some observers in Winston-Salem believe that the examiner owes an ethical duty to advise the respondent how the information generated by the evaluation might be used. In addition, there is some question whether the respondent's communications to the examiner are protected by a measure of doctor-patient privilege. Most scholars agree that little or no such privilege attaches during a court-ordered evaluation. However, if the examining physician is also the treating physician, as frequently is the case in Winston-Salem, the matter is not so clear. In a few jurisdictions, the treating physician may not act as the examining physician for the purposes of commitment.[60] In states without such laws, it may be

59. French v. Blackburn, 428 F. Supp. 1351 (M.D.N.C. 1977).
60. In Columbus, Ohio, each respondent is examined by a "court doctor" and by an "in-

acceptable for the treating physician to examine his or her patient for the purposes of commitment, so long as the patient is informed that the results of the examination might subsequently be used for commitment purposes.

Recommendation: Qualified physicians conducting prehearing examinations should explain to respondents the purpose of the examination and the way in which the information generated by the examination might later be used by staff of the mental health facility and the courts.

Another possible weakness in the North Carolina law and in the practice in Winston-Salem concerns the failure of the state to provide indigent respondents with the right to an independent mental health examination at the government's expense. Before the creation of such a right is undertaken, its costs and benefits must be carefully weighed. Independent examinations are important for two reasons. They provide an additional opinion in an area in which opinion reliability is low, and they provide an enhanced incentive for the state's examiner to be thorough. Furthermore, given that commitment decisions typically turn on the medical testimony, without the opportunity to generate independent medical evidence, the respondent may have little to draw on in developing a defense.

The cost of providing the right to an independent examination at the government's expense may or may not be great, depending on the frequency with which the right is exercised. Facility personnel in Winston-Salem indicate that it is extremely rare for a respondent to request an independent examination. Of course, if a right to such an examination at the government's expense were created and notice of this right were provided to the respondent, it is reasonable to presume that requests for such examinations would increase. However, research in states that entitle respondents to free independent examinations suggests that such examinations rarely are requested, even when notice of the right is provided.[61] Recognizing that independent examinations usually extend the prehearing period and rarely produce new information of use to the defense, counsel ordinarily advise respondents not to request independent examinations except where there is reason to question the original examiner's clinical judgment or objectivity.[62] Where such reason exists, few would deny that the respondent ought to have the opportunity for an independent assessment.

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dependent doctor;" the independent doctor is bound by the doctor-patient privilege, while the court doctor is not. I. KEILITZ, *supra* note 8, at 46.

61. W. FITCH, B. MCGRAW, J. HENDRYX & T. MARVELL, *supra* note 8, at 22.

62. *Id.*

Recommendation: Respondents in involuntary civil commitment proceedings who have been admitted to a mental health facility for detention pending a hearing should be accorded the right to an independent examination on request, to be provided at the government's expense if indigent. Notice of this right should be provided at the time of the examination described in section 122-58.6 of the North Carolina General Statutes.[63]

6. Prehearing Treatment

The North Carolina law is strong in its recognition of a right to treatment and a right to be free from unnecessary or excessive medication with drugs. The requirement that written consent be obtained before the administration of electroshock therapy, experimental drugs or procedures, or surgery (other than emergency surgery) also is to be commended, given the extraordinary intrusiveness of these procedures. However, the law's failure to address the question of the respondent's right to refuse less intrusive treatment is troubling.

Questions concerning the right to refuse treatment have arisen in the context of the committed person, and the courts have shown a varying degree of willingness to recognize the right. For the respondent detained pending a hearing, however, the "right" arguably is stronger for the following two reasons: (1) at this stage, the respondent has not yet been accorded full due process protections (i.e., has not yet been found by clear and convincing evidence to meet the criteria for involuntary care and treatment); and (2) the respondent may have an interest in being free from the effects of medication or other treatment while participating in his or her defense at the hearing. Furthermore, judges complain that it is often difficult to know whether a respondent's appearance and behavior in court represent his or her true mental condition or are the result of medication, making a determination of the respondent's suitability for commitment very difficult.

Recommendation: Pending a commitment hearing, the respondent should be accorded the right to refuse treatment except such emergency treatment as is necessary for the preservation of the health and safety of the respondent and the protection of other persons and property. If any medication is administered to the respondent during the prehearing detention period and the respondent's treating physician has any reason to believe that the respondent's behavior in court will be affected by such medication, the physician should indicate to the court in writing what medications were administered. Representatives of the mental health community in Winston-Salem should prepare a brief reference guide for the use of commit-

63. No independent examination need be provided as a check on the initial "screening" evaluation conducted pursuant to N.C. GEN. STAT. § 122-58.4 (1981).

ment judges indicating the behavioral effects of particular medications frequently used to treat psychiatric patients.

7. Conversion to Voluntary Status and Retention of Voluntary Patients

Lawyers, judges, and mental health professionals in other cities have complained that persons who are taken against their will to a psychiatric facility for prehearing detention frequently are coerced into becoming voluntary patients.[64] In some states, statutes have been enacted to prevent such coercion.[65] The problem of coerced voluntary admission appears not to exist in Winston-Salem. Rather, it is widely believed that respondents in Winston-Salem *too often* request and obtain conversion to voluntary status as a means of winning the right to request a speedier release from the hospital.

Most lawyers and psychiatrists in Winston-Salem agree that respondents may convert to voluntary status only with the approval of the court and that committed persons may convert only with the approval of the treating physician. Some people in the community believe that conversion requests too readily are approved and that, as a result, it has become exceedingly difficult to have someone committed involuntarily for an extended period of treatment. To the extent that a person's suitability for voluntary status is a treatment question, the policy of leaving the decision in the discretion of the treating physician (with court approval for respondent's prehearing) seems sound. But, if respondents are being allowed to convert to voluntary status without proper regard for their likelihood of remaining in treatment, some reform of policy or its application may be needed.

The procedures in Winston-Salem for dealing with voluntary patients who request their release are unclear. Many people in Winston-Salem believe that voluntary patients who request their release are *always* released and that this, coupled with the tendency of the facilities to grant respondents' requests for conversion to voluntary status, provides a way out of the hospital for most persons committed involuntarily. Personnel in the facilities report that if a voluntary patient requesting his or her release is dangerous (or otherwise meets the involuntary criteria), the facility either will arrange for a member of the patient's family to petition for involuntary commitment or, if the patient's condition is particularly acute and no family member is willing or able to file a petition, will have the patient's treating physician act as petitioner.

It obviously is important that facility personnel act to prevent the

64. J. ZIMMERMAN, *supra* note 8, at 44.
65. *See, e.g.*, ILL. ANN. STAT. ch. 91½, § 3-402 (Smith-Hurd Supp. 1981-82).

release of persons who meet the involuntary commitment criteria. Assuming that the practices in Winston-Salem are, in fact, as the facility personnel describe them to be, no recommendations for change appear to be needed. On the other hand, if the lay perception is more accurate, a change might be in order. Further objective study of this question would be necessary before a recommendation could be offered with any degree of confidence.

8. Prehearing Discharge

The law in North Carolina and the practice in Winston-Salem providing for the release of respondents and the termination of proceedings upon a finding of noncommittability at the initial examination protect both the liberty interests of respondents and the fiscal interests of the state. The procedure is especially valuable in the rural areas of the state, where it prevents the inappropriate removal of respondents to state hospitals outside of their communities. The law and practice regarding the respondent's status following a finding of noncommittability at the second examination are not so commendable. People in Winston-Salem and at the John Umstead Hospital in Butner agree that a respondent will not be committed if the physician's report to the court indicates that the respondent does not meet the commitment criteria. Therefore, the requirement that a hearing be held in such cases seems wasteful. The practice in some facilities in Winston-Salem to detain the respondent pending the hearing despite a finding of noncommittability at the second examination is contrary to law and seems particularly inappropriate.

In Winston-Salem, a number of people favor the requirement that a hearing be held (and some even believe it proper to continue to detain the respondent pending the hearing) even though the second examination results in a finding of noncommittability. Because the two evaluations are performed at the same facility, they contend, a disagreement between qualified physicians at least creates a question as to the respondent's committability. However, insofar as the two-examination requirement is designed to account for the unreliability of clinical assessment, giving the respondent the benefit of the doubt, a failure to release the respondent under such circumstances seems inappropriate. If the physician conducting the second examination has some question about the respondent's suitability for commitment, he or she should be permitted to consult the physician who conducted the initial examination before discharging the respondent, but if his or her conclusion is that the respondent is not commitable, the respondent should be discharged (as required by law) and the proceedings against him or her should be terminated (as demanded by logic and practicality). Pro-

spective hearing participants should be notified of the discharge and termination so they might avoid the effort and expense of preparing for and appearing in court. In order not to penalize the conscientious defense attorney who may have begun preparing the respondent's case (and, moreover, in order to promote a vigorous representation prior to hearing), the attorney appointed to represent the respondent at the hearing should be compensated despite the prehearing release and termination.

Recommendation: Upon a finding by the qualified physician conducting the second evaluation of the respondent (or the first if the respondent was detained pursuant to the emergency procedure or upon an affidavit submitted by a qualified physician) that the respondent does not meet the involuntary commitment criteria, the respondent should be discharged from the facility and facility personnel without delay should communicate this fact to the clerk of the court in which the hearing is pending. The clerk without delay should notify the respondent's counsel, the district attorney, the petitioner, and any witnesses who may have been summoned to appear at the hearing that the respondent has been found not to meet the commitment criteria and has been discharged. Neither the respondent nor the respondent's counsel should be required to appear in court on the day of the scheduled hearing, and the court should dismiss the proceedings against the respondent. The attorney appointed to represent the respondent at the hearing should be compensated despite the respondent's prehearing release.

The failure of the mental health facilities serving Winston-Salem to notify family members and others when a respondent is released is criticized by many people in the city. If, upon release of the respondent prior to hearing, the facility notifies the court and the court, in turn, notifies the respondent's counsel, the district attorney, the petitioner, and any witnesses summoned to appear at the hearing, most necessary notifications will be completed. There is some question, however, whether notification should be made to persons in the community whose safety may be threatened by the respondent once he or she is released. Although no one in Winston-Salem appears to be terribly concerned about this, a notification policy should be considered, if only to protect the legal interests of the hospitals and their staff.[66]

III. Counsel For the Respondent

Whether or not the court receives a complete picture of the respon-

66. *See* Tarasoff v. Regents of the Univ. of Cal., 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

dent's condition and is able to arrive at a thoughtful and appropriate disposition depends largely on the performance of the respondent's attorney. The attorney who fully explores the needs of his or her client and the available defenses and treatment options can do much to ensure that the court's decision is informed. Whether the attorney should zealously advocate for the expressed wishes of the respondent or pursue what he or she believes is in the respondent's best interests is one of the most frequently discussed questions in the civil commitment area.

A. *Description*

1. Right to Representation by Counsel

The law in North Carolina and the practice in Winston-Salem clearly recognize the right of all respondents in civil commitment proceedings to be represented by counsel. North Carolina law provides that respondents alleged to be mentally ill or mentally retarded must be represented by counsel; such respondents who are indigent or who refuse to retain counsel are to be assigned counsel. Respondents alleged to be inebriate may waive counsel, if the court determines that they are sober and capable of making an informed decision.[67] As a matter of practice, every respondent in a commitment proceeding in Winston-Salem is represented by counsel. Moreover, people in Winston-Salem estimate that more than ninety per cent of respondents are represented by assigned counsel.

2. The Manner in Which Counsel is Provided for Indigents

When a clerk or a magistrate issues a custody order, he or she must inquire whether the respondent is indigent.[68] In Winston-Salem, petitioners are asked to provide information concerning the respondent's financial status and intention to retain private counsel. If the petitioner indicates that the respondent is either indigent or not planning to retain counsel, or if the petitioner is unwilling or unable to provide this information, then, upon receipt of a physician's report stating that the respondent meets the involuntary commitment criteria, the clerk assigns counsel.

The clerk in Winston-Salem maintains a list of private attorneys in the community who are available for assignment in these cases. Ordinarily, an attorney will be assigned three cases to be heard on a particular day. The clerk makes an effort to assign attorneys for respondents who are detained in the same facility so that no attorney will have to visit more than one facility in preparing his or her cases for the hearing

67. N.C. GEN. STAT. § 122-58.7(b)-(c) (1981).
68. *Id.* § 122-58.3(c).

date. The clerk makes assignments by telephone and prepares an order of assignment for the judge's signature. Although notice of the hearing is required by statute to be provided to the respondent's counsel at least forty-eight hours in advance of the hearing,[69] some attorneys in Winston-Salem report having received assignments less than twenty-four hours before the hearing.

3. The Role of Counsel

The North Carolina statutes provide that assigned counsel in commitment proceedings are to serve as though they had been privately retained.[70] No further information concerning counsel's role is provided by statute.

Counsel for respondents in commitment proceedings in Winston-Salem generally assume the role of guardian *ad litem*, acting in what they perceive to be the best interests of the client. Most observers agree that attorneys rarely advocate aggressively for the release of their clients. Frequently, attorneys will allow (and even encourage) their clients to testify when they know that such testimony will result in commitment. In a number of cases observed by the research team, the respondent's counsel elicited testimony from witnesses or provided direct statements to the judge that seemed to strengthen the case for hospitalization. This apparently was done intentionally, presumably to impress the judge with the seriousness of the respondent's difficulties and need for treatment.[71]

Many people in Winston-Salem believe that the "best interests" position is the appropriate one for attorneys to take in involuntary commitment cases. Some believe that the proper role lies somewhere between guardian *ad litem* and advocate. Very few adhere to the advocacy approach. One attorney voiced the opinion that the central concern of the respondent's counsel should be to ensure that the respondent is not "railroaded," but this effort should stop short of "fighting to get the person out of the hospital." Another attorney noted that, although the "best interests" approach is favored by the local bar, he personally believes that commitment proceedings should be adversarial in nature and that the attorney should pursue whatever goals the client desires. This attorney admitted, however, that he does not "fight very hard against the system." A psychiatrist observed that "it would be pre-

69. *Id.* § 122-58.5.

70. *Id.* § 7A-450(b).

71. In one case, the respondent's counsel stated to the court that his client was an inebriate and was "as dangerous to herself as anyone I have ever seen." The attorney further reported to the court that his client had been hospitalized a number of times in the past and that another attorney with whom he had spoken who was familiar with the respondent had told him that he also thought the respondent was dangerous.

sumptive on my part to say what the role of counsel should be. The conflict is between liberty at any cost versus the best interests of the patient. As a physician, I lean toward best interests, but if I were a respondent, I would want the representation of a real advocate."

4. The Responsibilities of Counsel

The attorney assigned by the court for an indigent respondent is responsible for representing the respondent at the initial hearing and perfecting and concluding an appeal if there is one. Upon completion of an appeal or upon transfer of the respondent to a regional mental health facility if there is no appeal, the attorney is discharged. If the respondent is committed to a mental health facility in the community, the attorney remains responsible for representing the respondent until either the attorney is discharged by the court or the respondent is discharged from the community facility.[72]

In Winston-Salem it appears that counsel's service to the respondent ceases at the conclusion of the initial commitment hearing. Reportedly, assigned attorneys virtually never discuss the question of appeal with their clients, and, as a result, appeals of commitment orders are practically non-existent. Similarly, respondents committed to facilities in Winston-Salem reportedly receive no post-hearing representation from their assigned attorneys.

Although the North Carolina statutes specify no other responsibilities of the respondent's counsel, it generally is expected in Winston-Salem that counsel will meet with his or her client at least once prior to the hearing. One attorney voiced the opinion that "effective assistance of counsel" requires the attorney to interview the respondent, the respondent's treating physician, and the petitioner prior to the hearing. This attorney admitted, however, that few appointed attorneys were this thorough.

5. Counsel's Access to Information in Possession of the State or the Detaining Facility

There is no law in North Carolina specifically providing counsel in commitment cases with a right of access to any information in possession of the state or the detaining facility. However, as a matter of practice in Winston-Salem, all of the records in the court file are available to counsel, including the petition, the affidavit, and the reports of the examining physicians. Policies regarding the availability of hospital records vary from facility to facility. At one facility, no one is allowed access to a patient's records unless the patient has given written permis-

72. N.C. GEN. STAT. § 122-58.10 (1981).

sion. At another facility, records usually are available to the respondent's counsel "because it is important that the attorney have all the information available" about the respondent. However, a spokesperson at this facility reported that if a particular attorney were "the Clarence Darrow type," physicians at the facility were less likely to be cooperative in the provision of information.

One attorney indicated that he had had problems with access to records at all the local facilities. He indicated that the facilities are concerned about the confidentiality of records and that facility personnel had resisted his efforts to review records on a number of occasions in the past. He indicated, however, that when he persisted, the facilities usually "gave in and allowed me access to the information." Another attorney reported no particular difficulty gaining access to records at the facilities but complained that the physicians at the facilities sometimes were uncooperative in making themselves available to speak with him.

6. Procedures for Handling the Respondents' Rejection of the Assistance of Assigned Counsel

As indicated above, the law in North Carolina provides that respondents in involuntary commitment proceedings "shall be represented by counsel."[73] Few persons in Winston-Salem report ever having seen or heard of a respondent rejecting the assistance of appointed counsel. In the handful of cases recalled, the respondent's *pro se* request reportedly was denied.

7. Incentives and Disincentives for Counsel To Be Thorough

Assigned counsel ordinarily are compensated at the rate of fifty dollars per case. This relatively low rate of compensation may serve as a disincentive for attorneys to be thorough. Several observers suggested that, for fifty dollars, an attorney could be expected to do little more than meet with his or her client before the hearing, briefly review pertinent records, and provide representation at the hearing; any meaningful prehearing advocacy or serious effort to arrange for outpatient placement should not be expected. The practice in Winston-Salem of assigning three cases to each attorney for each hearing day, involving respondents all detained in the same facility prehearing, is regarded locally as providing an excellent incentive for attorneys to visit their clients and interview physicians before the hearing, however.

73. Respondents whose commitment is based on inebriety may waive counsel if sober and capable of making an informed decision. *Id.* § 122-58.7(c).

B. *Strengths, Weaknesses, and Recommendations for Improvement*

1. Right to Representation by Counsel

The law in North Carolina and the practice in Winston-Salem regarding the provision of counsel are exemplary. The requirement that non-indigent respondents be represented by assigned counsel if they fail to retain private counsel is particularly noteworthy. It protects the legal interests of persons who may not be capable of making a "knowing, intelligent, and voluntary" waiver of the right to representation.

2. The Manner in Which Counsel is Provided for Indigents

There are a number of different systems for providing counsel for indigents in commitment hearings, including the use of a public defender, the use of special advocates responsible exclusively or primarily for commitment cases, and the assignment of private attorneys available locally. Although no one in Winston-Salem faults the assignment system employed there, there is reason to believe that assignment systems result in less effective advocacy. First, private attorneys appointed to cases on an occasional basis typically have little expertise in the area of mental health law. Furthermore, because attorney compensation is relatively low, many of the attorneys attracted to these cases are new and inexperienced. As a result, attorney competence may be lower than it is in jurisdictions employing different types of defender systems.

Recommendation: The courts and their allied agencies in Winston-Salem should study the possibility of creating a new system for providing counsel for indigents in involuntary commitment cases. Specific consideration should be given to the special counsel system employed in North Carolina's regional hospitals.

The manner in which the clerk or magistrate determines whether a prospective respondent is indigent seems reasonable. Indeed, a more thorough investigation than that which is presently conducted by the clerk or magistrate at the time that the affidavit is submitted would probably cost the state more than the fifty dollars which is ordinarily paid to the attorney.

The occasional failure of the court to assign counsel for the respondent at least forty-eight hours in advance of the hearing is a serious weakness in the commitment system in Winston-Salem. In order to adequately prepare the respondent's case, counsel always should be given *at least* forty-eight hours' notice.

Recommendation: Assignment of counsel always should be made at least forty-eight hours before the time scheduled for hearing.

3. The Role of Counsel

Although there appears to be a consensus in Winston-Salem that the proper role for the respondent's counsel is to act as a guardian *ad litem*, serving the "best interests" of the respondent, it should be noted that Winston-Salem is not in the mainstream of contemporary legal thought in this regard. In the statutes and case law of many other states, it is clear that counsel are being directed to serve as vigorous advocates for their clients' stated interests.[74] Moreover, it can be argued that because North Carolina law requires the assigned attorney to represent the respondent as though he or she were privately retained,[75] the guardian *ad litem* model may be legally insufficient.

The diagnosis of mental disorder is widely regarded as an imprecise endeavor.[76] Moreover, recent studies have shown that psychiatric predictions of future dangerousness are terribly unreliable.[77] Because of this, it is inappropriate for anyone to accept without question psychiatric opinion that a respondent is mentally disordered and dangerous. Because *psychiatrists* have difficulty assessing respondents' suitability for commitment, it certainly is unrealistic to assume that respondents' *attorneys* can know what is in their clients' best interests. This is particularly true in jurisdictions employing counsel assignment systems that attract inexperienced attorneys.

To the extent that the state is adequately represented in commitment proceedings and that the laws and procedures governing these proceedings are reasonable, a strong advocacy representation by the respondent's counsel should make it no more difficult for the court to determine the most appropriate disposition for a case. Moreover, a vigorous representation by the respondent's attorney is likely to engender a more vigorous representation by the district attorney. As a result, the court should receive a more complete picture of the respondent's condition and the treatment, if any, that is appropriate.

Because the role of counsel has not been the subject of serious concern in Winston-Salem, no major changes will be recommended in this article. It should be stressed, however, that this aspect of the city's commitment system has the potential for investigation and challenge. Pressures to change the role of counsel may arise in the future and should not come as a surprise.

74. *See, e.g.*, Mich. Prob. Ct. Rules 732(2); Memmel v. Mundy, 75 Wis. 2d 276, 249 N.W.2d 573 (1977).

75. N.C. GEN. STAT. § 7A-450(b) (1981).

76. *See* Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974).

77. J. MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR (DHHS Pub. No. ADM 81-921) (1981).

4. The Responsibilities of Counsel

The statutory requirement that counsel represent the respondent at the initial hearing, on appeal, and during the period of commitment if the respondent is committed to a local facility is a strong feature of the commitment law in North Carolina. The failure of counsel to provide post-hearing assistance is a major weakness in the city's commitment system. This issue is discussed further in the Post-Hearing Concerns section.

Given the consensus among attorneys, clinicians, and judges in Winston-Salem that counsel for the respondent should, *at a minimum*, meet with and interview the respondent before the day scheduled for the hearing, it may be fair to assume that respondents whose attorneys meet them for the first time at their hearings are denied the effective assistance of counsel.

Recommendation: Counsel for the respondent should be required to meet with the respondent and discuss the respondent's case at least one day before the hearing date. If it is determined that counsel failed to comply with this requirement, the court should refuse to compensate counsel for services rendered and should offer the respondent the opportunity to have his or her case adjourned in order for new counsel to be assigned. Further, unless counsel is able to provide an adequate reason for failing to comply with this requirement, he or she should be removed from the list of attorneys eligible for appointments of commitment cases.

5. Counsel's Access to Information in Possession of the State or the Detaining Facility

The practice in Winston-Salem of allowing the respondent's attorney access to information contained in the respondent's court file compensates, to some extent, for the failure of the North Carolina commitment statutes to guarantee the respondent or the respondent's counsel access to information in the state's possession. However, the policy of some of the local treatment facilities to restrict access to the respondent's records is a weakness of the commitment system in Winston-Salem. Given that any information provided to the respondent's counsel becomes privileged, the facility can have some assurance that the information provided will not be used to harm the respondent. Furthermore, the competency of respondents in commitment proceedings to decide who should be permitted access to their records arguably is questionable. To deny the respondent's counsel access to records simply because the respondent fails to give consent may, indeed, work to the ironic disadvantage of the respondent.

Recommendation: The respondent's attorney should be provided access to the respondent's hospital records regardless of whether the respondent has provided expressed consent.[78]

The inaccessibility of some examining physicians to respondents' attorneys is a serious weakness in the commitment system in Winston-Salem. In order to prepare a competent defense, it is necessary for counsel to interview the medical experts prior to the hearing. This concern is particularly compelling in North Carolina, where indigent respondents have no right to an independent examination at the government's expense.

Recommendation: Mental health facilities in Winston-Salem should encourage the physicians on their staffs to meet with attorneys wishing to interview them concerning respondents in commitment proceedings.

6. Procedures for Handling the Respondent's Rejection of the Assistance of Appointed Counsel

The requirement of the statute that the respondent be represented by counsel (unless the grounds for commitment are inebriety and the respondent is found to be competent) would seem to deny the respondent the option of representing himself or herself. The United States Supreme Court has recognized a qualified right of defendants in *criminal* proceedings to represent themselves if they are competent to waive the right to counsel.[79] Nevertheless, the North Carolina requirement probably is reasonable, given that the competency of allegedly mentally disordered respondents to waive the right to counsel is inherently questionable. The general reasonableness of the North Carolina law, coupled with the infrequency with which respondents in Winston-Salem attempt to reject the assistance of counsel, suggests that further discussion of this issue would serve no useful purpose.

7. Incentives and Disincentives for Counsel To Be Thorough

There is a great likelihood that the relatively low compensation provided to assigned counsel acts as a disincentive for these counsel to be thorough. Although the practice of assigning three cases to each attorney for each hearing day remedies this to some extent, the lack of provision for awarding a higher-than-usual fee when an attorney has devoted an extraordinary amount of time to a case is regarded as a

78. Should facility personnel be reluctant to comply with this recommendation for fear of liability to the respondent for disclosing confidential information without consent, an advisory opinion from the State Attorney General or a statutory amendment permitting such disclosure should be solicited or pursued.

79. Johnson v. Zerbst, 304 U.S. 458 (1937).

weakness in the city's commitment system. If the award of higher fees in extraordinary cases were possible, the cost of the commitment system might rise. On the other hand, to the extent that additional efforts by defense counsel would result in fewer commitments, the costs to the state of providing treatment would be saved, and the net result might be a less costly system.

Recommendation: The judges of the district court should discuss and explore the possibility of establishing guidelines for awarding a higher-than-usual fee to any attorney who demonstrates having devoted an extraordinary amount of time to the representation of a respondent in a commitment proceeding.

IV. THE HEARING

The various pieces of information about the respondent generated during the prehearing processing of the case, including the petitioner's allegations, the witnesses' statements, the examining physicians' opinions, and any legal considerations, are fitted together for independent assessment by a judge at the commitment hearing. Whether the pieces fit well and present a fair and complete picture of the respondent's condition and of the various dispositional alternatives available to the court is largely a function of the quality of the procedures employed during the hearing.

A. *Description*

1. General Considerations

It is both the law in North Carolina and the practice in Winston-Salem for every respondent in a commitment proceeding to have a hearing before the district court within ten days of the day he or she is taken into custody.[80] In Winston-Salem, even during holiday seasons (when the court may not be sitting on its usual day), arrangements reportedly are made for hearings to be held within the ten-day period.[81]

The clerk of the superior court is required by statute to notify the respondent and the respondent's attorney at least forty-eight hours in advance of the hearing, unless notice is waived by the respondent's attorney.[82] Additionally, the court must provide notice of the hearing to

80. N.C. GEN. STAT. § 122-58.7(a) (1981).

81. *Id.* Commitment cases in Winston-Salem are heard by judges of the Twenty-First Judicial District Court. The judges hear cases without a jury. The five judges of the court rotate assignments every month. Civil commitment cases are the responsibility of the judge in the "swing" rotation. The swing rotation consists primarily of domestic relations cases; commitment cases represent only about two hours of the judge's work week.

82. *Id.* § 122-58.5.

the petitioner at least forty-eight hours in advance, unless waived.[83] Reportedly, these notifications always are made in Winston-Salem, but not always within forty-eight hours of the hearing.

The statutes in North Carolina provide that hearings may be held at the mental health facility in which the respondent is being treated (but not in a treatment room) or in the judge's chambers. Hearings may not be held in a regular courtroom over the respondent's objection if the judge determines that a more suitable place is available.[84] Hearings are to be closed to the public unless the respondent requests otherwise.[85]

In Winston-Salem, commitment hearings are held every Thursday afternoon at the Hall of Justice in a courtroom that has a glass partition separating the hearing participants from the spectators. Present during the hearings observed by research staff from the National Center for State Courts were the judge, the assistant district attorney, one clerk, two bailiffs, one court reporter, and several respondents and their attorneys. Witnesses and other observers were seated behind the glass partition.

2. The Criteria and Standard of Proof for Involuntary Commitment

Before a commitment may be ordered in North Carolina, the court must find by clear, cogent, and convincing evidence that the respondent is mentally ill or inebriate and dangerous to self or others, or mentally retarded and, because of an accompanying behavior disorder, dangerous to others. The court must record the facts that support its findings.[86]

When applied to an adult, "mental illness" is defined as "an illness which so lessens the capacity of the person to use his customary self-control, judgment, and discretion in the conduct of his affairs and social relations as to make it necessary or advisable for him to be under treatment, care, supervision, guidance, or control."[87] An inebriate person is defined as one who is "habitually so addicted to alcoholic drinks or narcotic drugs or other habit forming drugs as to have lost the power of self-control and that for his own welfare or the welfare of others is a proper subject for restraint, care, and treatment."[88] A mentally retarded person is defined as one "who has significantly sub-average general intellectual functioning existing concurrently with deficits in

83. *Id.* § 122-58.20(a).
84. *Id.* § 122-58.7(f).
85. *Id.* § 122-58.7(g).
86. *Id.* § 122-58.7(i).
87. *Id.* § 122-36(d).
88. *Id.* § 122-36(c).

adaptive behavior and manifested during his developmental period."[89] "Behavior disorder" is defined as "a pattern of maladaptive behavior that is recognizable by adolescence or earlier and is characterized by gross outbursts of rage or physical aggression against other persons or property."[90]

A person is considered to be dangerous to self if "he would be unable without care, supervision, and the continued assistance of others 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; and . . . there is a reasonable probability of serious physical debilitation to him within the near future unless adequate treatment is afforded . . . . A showing of behavior that is grossly irrational or of actions which the person is unable to control or behavior that is grossly inappropriate to the situation or other evidence of severely impaired insight and judgment shall create a prima facie inference that the person is unable to care for himself . . . ."[91] A person also is considered to be dangerous to self if he or she has attempted or threatened suicide and there is a reasonable probability of suicide unless adequate treatment is afforded, or has mutilated or attempted to mutilate himself or herself and there is a reasonable probability of serious self-mutilation unless adequate treatment is afforded.[92] A person is considered to be dangerous to others if, within the recent past, he or she has inflicted, attempted to inflict, or threatened to inflict serious bodily harm on someone else or has acted in such a manner as to create a substantial risk of serious bodily harm to someone else and there is a reasonable probability that this conduct will be repeated.[93] Thus, "dangerousness" in North Carolina includes both "active" dangerousness (violence) and "passive" dangerousness (inability to care for self, termed "grave disability" in some states).

People in Winston-Salem generally agree that these statutory criteria are substantially observed by the district court judges in Winston-Salem. In the hearings observed by the research team, the judge in every case specified in his commitment orders the criteria satisfied and the facts supporting his findings.

3. The Role of the District Attorney

Assistant attorneys general assigned to the state's four regional psy-

89. *Id.* § 122-36(e).
90. *Id.* § 122-58.2(4).
91. *Id.* § 122-58.2(1).
92. *Id.*
93. *Id.*

chiatric facilities are responsible for representing the state's interests at commitment hearings, rehearings, and supplemental hearings held at these facilities.[94] The law, however, does not provide for the state's representation in hearings held outside of the regional facilities.

In Winston-Salem, an assistant district attorney represents the state in commitment hearings. Commitment hearings account for only a part of this district attorney's caseload. The role that the district attorney assumes in commitment cases in Winston-Salem reportedly is to present the facts, not to make arguments. One local observer suggested that "it is more of an administrative chore than a lawyering effort." One of the local psychiatrists stated that, although the commitment proceeding is cast as an adversarial one, the district attorney does not see her role as adversarial. Petitioners occasionally bring attorneys to court to represent their interests. When this happens, the district attorney reportedly allows the private attorney to present the case for the state.

4. The Role of the Judge

Although the law in North Carolina does not specify a particular role for judges in civil commitment cases, it generally is agreed in Winston-Salem that the proper role of the judge (and the role assumed by most judges in the District Court) is to act as a neutral and detached hearing examiner—to hear the evidence, rule on objections, decide whether the evidence proves by the required standard that the respondent meets the criteria for involuntary commitment, and, if the respondent is found to meet the criteria, determine whether outpatient or inpatient treatment is appropriate.

5. The Presence of the Respondent at the Hearing

The law in North Carolina provides that counsel may waive in writing the presence of the respondent with consent of the court.[95] As a matter of practice in Winston-Salem, the respondent's presence frequently is waived. Reportedly, attorneys in Winston-Salem routinely waive their client's appearance in three situations: when the client is so obviously disordered that his or her appearance in court would serve only to damage the defense, when the other evidence to be presented probably will result in the client's release (e.g., the physician's report recommends discharge), and when the client expresses a wish not to resist commitment (i.e., either has converted to voluntary status or sim-

94. *Id.* § 122-58.24.
95. *Id.* § 122-58.7(d).

ply does not object to involuntary treatment). One judge estimated that waivers occur in fifty percent of the cases.

Waivers are submitted to the court in writing, signed by the respondent's counsel. The respondent is not required to sign the waiver. However, one attorney stated that, in order to protect himself, he always has the respondent sign a form indicating that he or she agrees to the waiver.

By most accounts, respondents typically are under the influence of medication during their hearings. Some observers report that it is not unusual for respondents to be so under the influence of medication that they do not appear to understand the courtroom proceedings.

6. The Presence of the Examining Physician at the Hearing

North Carolina law provides that certified copies of physicians' reports and hospital records are admissible in evidence.[96] Respondents retain the right to confront and cross-examine witnesses, however.[97]

As a matter of practice in Winston-Salem, physicians almost never appear in court to testify. One judge estimated that physicians have testified in fewer than twenty commitment cases in his court in the last seven years. It generally is expected that the respondent's counsel will stipulate to the medical report proffered by the district attorney. In cases in which the respondent's counsel refuses to stipulate to the report, the judge reportedly will either ask the respondent's counsel to agree to a continuance for one week or adjourn the case until later in the day (or until another day within the ten-day prehearing period) in order for arrangements to be made for the physician to appear. Judges in Winston-Salem are said to admonish attorneys for refusing to stipulate, criticizing them for failing to use the prehearing period to work out informally any problems they may have with the physician's report.

If the physician's attendance is requested, the physician may or may not appear in court. It was reported that some physicians will attend but that others simply will report that the respondent no longer meets the commitment criteria. One attorney suggested that, by refusing to stipulate, the respondent's attorney can almost guarantee dismissal of the respondent's case.

The Winston-Salem court staff complain that physicians' reports usually are handwritten and sometimes are illegible. While the technical quality of medical reports is considered to vary greatly, most reports are said to be largely repetitive of information on the petition, containing little original material from the physician. One attorney claims that

96. *Id.* § 122-58.7(e).
97. *Id.*

the reports are so incomplete that they present a small obstacle to the attorney determined to have his or her client released.

7. The Presence of the Petitioner and Witnesses at the Hearing

The petitioner reportedly attends the hearing and presents evidence to the court in almost every commitment case in Winston-Salem. Other witnesses frequently testify as well.

8. Public Access to Hearings

North Carolina law provides that the hearing is to be closed to the public unless the respondent requests otherwise.[98] The practice in Winston-Salem is for spectators at hearings (including witnesses when not testifying) to sit in the courtroom behind a glass partition. Spectators can view the proceedings but, reportedly, cannot hear because of the partition. Exceptions to the practice of requiring non-participants to sit behind the partition are made for other respondents whose cases are to be heard by the court the same day (they sit in the jury box within earshot of proceedings) and visitors receiving special permission from the court.

9. Continuances

North Carolina law allows for continuances of up to five days on motion of the respondent's counsel.[99] The statutes provide further that if the court has sufficient evidence to order commitment but lacks sufficient evidence to determine whether the commitment should be inpatient or outpatient, it may continue a case for disposition up to seven days for the production of evidence to help in determining disposition. Continuances of this type may be granted on motion of the respondent's counsel, the state's attorney, or on the court's own motion.[100]

In practice, continuances are rare in Winston-Salem. Judges recognize that only the respondent ordinarily may move for a continuance. One judge reported that, in his court, continuances are not granted unless agreed to by both sides.

As indicated elsewhere, if the respondent's counsel refuses to stipulate to a medical report, the judge may delay hearing the case for a short period of time (not beyond the ten day prehearing period) to make arrangements for the physician to attend the hearing. Because the delay never serves to continue the case beyond the ten day prehear-

98. *Id.* § 122-58.7(g).
99. *Id.* § 122-58.7(a).
100. *Id.* § 122-58.8(b).

ing period, people in Winston-Salem refer to these delays as "adjournments" and consider them not subject to the continuance regulations.

10. Rules of Evidence and Rules of Procedure

Although commitment hearings in Winston-Salem generally are less formal than other kinds of trials, rules of evidence and rules of procedure generally are observed by the judges. The judges report that formal rules are applied to the extent that objections are made but the attorneys rarely object.

The judges indicate that evidence of previous commitments frequently is presented in hearings with no objection from the respondent's counsel. Indeed, evidence of previous commitments often is contained in the medical reports to which respondents' counsel routinely stipulate. The judges speculate that an objection to the admissibility of such evidence probably would be sustained. Although the statutes do not address the question of whether evidence of previous commitments is admissible, to the extent that such evidence relates to behavior that is not current, an argument can be made that it is irrelevant; few would deny that it is prejudicial. Moreover, the statutes *do* provide that evidence of previous *voluntary* admissions is inadmissable.[101]

Hearsay evidence also frequently is admitted, primarily because the attorneys fail to object to its admission. A local psychiatrist reported that petitions often contain allegations that, in his opinion, are either fabricated or highly exaggerated and that the reports of examining physicians routinely refer to these allegations as though they were fact. To the extent to which these reports are stipulated, information of dubious reliability is entered into evidence with no objection.

11. The Question of the Respondent's Competency to Make Treatment Decisions

The North Carolina statutes provide that an involuntary commitment "shall in no way affect incompetency proceedings . . . ."[102] No one in Winston-Salem suggested to this research staff that the rulings of the court at the commitment hearing had any bearing on respondent's competency to make treatment decisions once committed.

12. The Presentation of a Treatment Plan

North Carolina statutes provide that a written treatment or habilitation plan must be formulated within the first thirty days of the respon-

101. *Id.* § 122-56.6.
102. *Id.* § 122-55.

dent's hospitalization.[103] Treatment plans typically are not presented at hearings in Winston-Salem.

13. The Role of Less Restrictive Alternatives

Conceptually, less restrictive alternatives may be viewed as a threshold concern of the question of committability (i.e., if a less restrictive program of care is appropriate, involuntary treatment may not be ordered) or as a placement concern of the commitment order (i.e., the respondent's commitment must be to the least restrictive program that is appropriate). In North Carolina, less restrictive alternatives are recognized primarily as a placement concern of the commitment order. There is no statutory provision in North Carolina requiring the court to find an absence of less restrictive alternatives before committing someone to involuntary treatment. The law does provide, however, that, upon a finding that the respondent meets the commitment criteria, the court may order treatment on an inpatient or an outpatient basis.[104] Before ordering outpatient treatment, the court must make findings of facts as to the availability and appropriateness of the outpatient treatment program.[105] Although the decision to commit is not specifically subject to the least restrictive alternative doctrine, the law does require that committed persons be discharged as soon as a less restrictive mode of treatment is appropriate.[106]

When talking about less restrictive alternatives with lawyers and psychiatrists in Winston-Salem, the conversation invariably turns to the question of how to make court-ordered outpatient treatment work. No one collects information about programs in the community that might be used for outpatient treatment. Moreover, there seems to be a consensus that the court has little power to enforce compliance with an order of outpatient treatment.

There is a procedure under North Carolina law by which respondents who fail to comply with outpatient treatment may be required to enter inpatient treatment.[107] The director initiates the action by notifying the attorney general of the respondent's non-compliance. The attorney general then notifies the clerk of the court in the county in which the respondent was committed for outpatient treatment and the clerk of the court in the county where the inpatient mental health facility is located. The clerk in the county in which the respondent was committed for outpatient treatment issues an order for the detention of the

103. *Id.* § 122-55.6.
104. *Id.* § 122-58.8(b) (*amended by* N.C. GEN. STAT. § 122-58.8(a)(1) (Cum. Supp. 1983)).
105. *Id.*
106. *Id.* § 122-58.1.
107. *Id.* § 122-58.8(c) (*amended by* N.C. GEN. STAT. § 122-58.10B (Cum. Supp. 1983)).

respondent in the appropriate mental health facility. When the respondent arrives at the facility, the clerk of the court in that county calenders a "supplemental hearing" to be held within ten days of the time that the respondent was taken into custody. At the supplemental hearing, the court must find by clear, cogent, and convincing evidence:

(1) that the respondent had been given a copy of the outpatient treatment plan and that the plan had been explained to the respondent;
(2) that the respondent had not adhered to the prescribed outpatient treatment program, and;
(3) that the respondent meets the criteria for involuntary commitment.

If the court makes these findings, it may order inpatient treatment for a period of up to ninety days.

The supplemental hearing procedure is not used in Winston-Salem reportedly because the requirement that an attorney general be involved makes it more cumbersome than simply beginning a new commitment proceeding. In practice, though, new commitment proceedings rarely are begun in these cases either. Indeed, the court in Winston-Salem does not often order outpatient treatment because of the difficulties associated with enforcing compliance.

14. The Court's Role in Determining Place or Conditions of Treatment

The extent of the court's authority to specify the terms of treatment lies in its discretion to order outpatient or inpatient commitment to a particular facility. The judge may specify neither a mandatory minimum treatment period nor the provision of particular modalities of treatment.

The facilities to which respondents most often are committed by the court in Winston-Salem are the Forsyth-Stokes Community Mental Health Center, Forsyth Memorial Hospital, the Mandala Center, and the John Umstead Hospital in Butner. Commitments to the John Umstead Hospital typically are made only when the respondent is unusually violent or is expected to require long-term care. Typically, respondents in Winston-Salem are committed to the institution in which they were detained prior to hearing.

B. *Strengths, Weaknesses, and Recommendations for Change*

1. General Considerations

The requirement that hearings be held in every case (rather than

only on the respondent's request, as in some states[108]) is a strong feature of the North Carolina law and procedure. Most observers agree that it would be unrealistic to presume that respondents in civil commitment proceedings would have the capacity to make intelligent decisions concerning the appropriateness of contesting their commitments in court, were they required to. Although many people in Winston-Salem believe that the level of due process built into the commitment law in North Carolina is excessive, few question the hearing requirement.

The requirement that hearings be held within ten days of the day the respondent is taken into custody is probably reasonable, given the way in which cases are processed prior to the hearing in Winston-Salem. Some states require that a probable cause hearing be conducted soon after the custody-taking to guard against erroneous confinement. In Winston-Salem, however, the screening of allegations conducted by the clerk or magistrate, coupled with the medical screening (initial evaluation by a qualified physician), probably provide adequate protection against this. Further discussion of this issue appears in the Prehearing Detention section.

The provisions requiring that the respondent, the respondent's counsel, and the petitioner be notified of the hearing at least forty-eight hours in advance are commendable. The failure of the court to assign counsel within the forty-eight hour period in every case should be considered a serious problem, however. Further discussion of this issue appears in the Counsel section.

The practice in Winston-Salem of holding hearings in a courtroom may not comply with the spirit of the North Carolina statutes. However, it is convenient for the court and, arguably, is minimally violative of respondents' legal and personal interests. Given the number of people who participate in hearings in Winston-Salem, it would be difficult, if not impossible, to conduct hearings in the judges' chambers. The question of whether hearings are sufficiently closed to the public is addressed later in this section.

2. The Criteria and Standard of Proof for Involuntary Commitment

The criteria for commitment in North Carolina are consistent with commitment criteria in other states, and the standard of proof meets the requirements articulated by the United States Supreme Court.[109] There is general agreement in Winston-Salem that the criteria are

108. *See* W. FITCH, B. MCGRAW, J. HENDRYX & T. MARVELL, *supra* note 8, at 37; I. KEILITZ, W. FITCH, & B. MCGRAW, *supra* note 8, at VII-1.

109. Addington v. Texas, 441 U.S. 418 (1979).

workable. One psychiatrist observed that the criteria "strike a reasonable balance between civil rights and the protection of the community."

Two persons in Winston-Salem, an attorney and a psychiatrist, expressed concern about the requirement that respondents be shown to be dangerous, referring to the notoriously low reliability with which predictions of violent behavior are made.[110] The psychiatrist stated that, in his opinion, very few respondents in Winston-Salem truly are dangerous. He suggested that if dangerousness is, indeed, the appropriate criterion for commitment, many people in Winston-Salem are being committed inappropriately. It may be possible, however, that this psychiatrist and others in Winston-Salem do not fully appreciate the meaning of dangerousness as it is defined in the North Carolina statutes. Indeed, it is likely that they think of dangerousness solely in terms of the respondent's propensity for violent behavior and are not sufficiently sensitive to that part of the definition describing someone who simply is unable to care for himself or herself.

3. The Role of the District Attorney

Although not required by statute in North Carolina, the practice in Winston-Salem of requiring the district attorney to represent the state is an important feature of the city's commitment system. It is generally recognized in Winston-Salem that the presence of a state's attorney is essential in commitment hearings, if only to ensure that the judge will not feel compelled to assume the role of "prosecutor" in these cases. Moreover, it can be argued, if the respondent is going to be represented by counsel at this hearing, the balance of the proceeding can be maintained only if the state also is represented.

In practice, the district attorney is said not to provide zealous representation. Because assigned counsel usually are not vigorous advocates either, the level of advocacy presented by the district attorney may not be entirely inappropriate. However, the commitment system may, and probably should, evolve to the point where counsel for respondents assume a stronger advocacy role. If and when this occurs, it will be necessary for the district attorney's role to change as well. Because the adversarial system of law is based on a balanced presentation of the two sides of a case, a strong advocacy position by the respondent's counsel or the district attorney will demand a response in kind.

Two potential problems can be identified with the practice of allowing petitioners' attorneys to represent the state. First, if the petitioner's attorney advocates vigorously for hospitalization, the respondent may be at a serious and unjustifiable disadvantage if his or

110. The professional literature is rife with demonstrations that predictions of violent behavior are wrong much more frequently than they are right. *See* J. MONAHAN, *supra* note 77.

her counsel assumes the role of guardian *ad litem*. Second, to the extent that a particular petitioner's motives in proceeding against the respondent are malicious or otherwise inappropriate, allowing the petitioner's personal attorney to represent the interests of the state (which are presumed to be beneficient) would be undesirable.

4. The Role of the Judge

The role assumed by judges in commitment proceedings in Winston-Salem—a neutral and detached hearing examiner—is generally applauded by observers in the city. A discussion of the judge's role in enforcing the rules of evidence and procedure appears later in this section.

5. The Presence of the Respondent at the Hearing

While many people in Winston-Salem believe that the frequent waiver of the respondent's appearance at the hearing is appropriate, either as a recognition of the respondent's wishes or as an expression of concern for the respondent's emotional stability, others are critical of this practice. They point out that the legal tradition in this county holds strongly to the notion that a person's liberty should not be curtailed without the person having heard and had an opportunity to confront his or her "accusors." One local psychiatrist opined that it was "fundamentally unfair" for the respondent's counsel to waive the respondent's presence. Moreover, he suggested, the respondent's participation in all stages of the process has therapeutic value, as it presents a fact-related basis on which the respondent might understand why treatment is being imposed.

Allowing the respondent's counsel to decide whether or not the respondent should attend the hearing is particularly troublesome. Many appointed attorneys have limited legal experience and few have any meaningful understanding of mental disorder. For an attorney to decide that a client need not attend the hearing because the client probably will be committed in any event is an improper substitution of the attorney's opinion regarding committability for the court's. With regard to respondents who express a wish not to attend, it is at least arguable that the competency of these individuals to make such a decision is questionable. Finally, it is important that the respondent be present at the hearing so that the judge will have an opportunity both to observe the respondent's behavior and to consider the respondent's expressed wishes. Requiring the respondent's presence should reduce the likelihood that the judge will either commit unnecessarily or release improperly.

Recommendation: The respondent's attendance at his or her hearing should be mandatory unless the respondent's attending physician states in writing that the respondent's appearance in court would substantially impair the respondent's mental or emotional stability or would seriously threaten the safety of others.

Whether respondents should appear in court under the influence of medication is a controversial question. Some suggest that medication enables the respondent to more effectively participate in the proceedings and assist in his or her defense; others argue that medication renders the respondent essentially absent from the proceedings. All would agree that overmedication is inappropriate. Because so many respondents are medicated at hearings in Winston-Salem, many people in the city express concern that it is impossible for the judge to know whether the respondent's behavior in court accurately reflects his or her mental condition or is a consequence of medication. Further discussion of this issue is presented in the Prehearing Treatment discussion.

6. The Presence of the Examining Physician at the Hearing

The routine absence of any mental health professional at the commitment hearing is perhaps the most significant difference between commitment proceedings in Winston-Salem and commitment proceedings in other cities. The question of whether the examining physician should be required to attend the hearing is a controversial one in Winston-Salem. Some believe that, if required to attend, physicians would be reluctant to recommend commitment, simply to avoid going to court. Therefore, they contend, the notion of requiring the physician's attendance is unrealistic. Others believe that examining physicians should be required to attend hearings and present oral testimony in every case. One psychiatrist voiced the opinion that the current practice amounts to a "medical model" for commitment decision-making. Because physicians' reports routinely are stipulated to, the recommendations of the physicians generally control the outcomes of the cases, he observed. If the examining physician were required to present his or her findings in open court, he suggested, the judge would be better able to assess the basis for the physician's opinion and arrive at an independent determination of whether commitment was necessary. This psychiatrist stated that he simply was not comfortable with the responsibility of making what he regards as the *social* decision of who should (or should not) be committed to treatment. Another psychiatrist, while agreeing in principle that examining physicians should appear in court to present their findings, was concerned that such a practice would severely strain the resources of the local facilities. Yet another psychiatrist in Winston-Salem dismissed the suggestion that examining

physicians be required to attend hearings as too expensive and logistically difficult.

Several people in Winston-Salem suggested that if hearings were held at the local mental health facilities, requiring the attendance of psychiatrists would be much less objectionable. Others observed, however, that because there are three facilities in Winston-Salem that function as prehearing detention facilities, this practice would be logistically difficult and cost-ineffective.

Recommendation: Under ordinary circumstances, the findings of the examining physician should not be admitted into evidence unless presented in oral testimony by such physician. Should the court not wish to require the attendance of physicians at hearings, a telephone communications system should be employed to enable examining physicians to present their testimony and submit to cross examination by telephone. Should the court decide against employing such a system, it should refuse to allow the respondent's counsel to stipulate to the report of the examining physician absent a representation by the respondent's counsel that he or she discussed the possible consequences of the stipulation with the respondent and the respondent acquiesced in the stipulation.

Because of the illegibility of some physicians' handwriting, the submission of handwritten reports to the court has become a major problem in Winston-Salem.

Recommendation: All reports submitted to the court by examining physicians should be typed or neatly printed.

7. The Presence of the Petitioner and Witnesses at the Hearing

The fact that petitioners are virtually always present to testify at hearings is a strong feature of the Winston-Salem commitment system. Research in other cities has revealed that the testimony of petitioners and other lay witnesses often is not available to the court and, as a result, the allegations of the petitioner typically enter into evidence (if at all) as hearsay in the examining physician's testimony.[111] The court in Winston-Salem should continue to encourage the attendance of petitioners in these cases.

8. Public Access to Hearings

The law requiring that hearings be closed to the public unless the respondent requests otherwise protects the personal and legal interests of respondents but may be difficult to strictly implement in practice.

111. *See* J. ZIMMERMAN, *supra* note 8, at 75.

Moreover, to the extent that the law prevents the court from making exceptions for researchers and others having a compelling social interest in attending and whose attendance would have no foreseeable detrimental effect on the respondent's interests, the law may be unnecessarily restrictive.

Recommendation: The statute requiring that commitment hearings be closed unless the respondent requires otherwise should be amended to allow the court to make exceptions for researchers and others having a compelling social interest in attending and whose attendance would have no foreseeable detrimental effect on the interests of the respondent.

The practice in Winston-Salem of holding hearings in full view of the public may violate the statutory requirement that hearings be closed to the public. It generally is accepted that respondents have a legitimate interest in privacy during the commitment hearing. It is unclear what benefits are derived from the practice of allowing the public to view the proceedings.

Recommendation: Measures should be taken to ensure that the general public is unable to view commitment hearings.

The practice of seating other respondents in the courtroom within earshot of the proceedings is in violation of the statute. Although no one in Winston-Salem suggested to the research staff that this arrangement had created problems or that respondents had objected to the presence of other respondents, the court should be sensitive to the statutory violation this practice represents and should consider other seating arrangements for these respondents.

Recommendation: The court should investigate the feasibility of sequestering respondents from the courtroom during hearings in which they are not involved.

9. Continuances

In contrast to many other cities, where restrictions on continuances frequently are ignored, the North Carolina laws governing continuances seem to be observed faithfully by the judges in Winston-Salem. This is a strong feature of the city's commitment system and is particularly important since the prehearing detention period in North Carolina may be relatively lengthy to begin with (up to ten days permitted by statute). The practice of permitting brief adjournments, within the statutory period, to allow the examining physician to be summoned to court apparently is not considered objectionable by anyone in Winston-Salem and has obvious functional utility.

10. Rules of Evidence and Rules of Procedure

Commitment cases frequently are based on allegations made by family members and often grow out of ongoing family disputes. As a result, the allegations on the petition and the testimony of the state's lay witnesses may not always be entirely objective. Because of this and because respondents so frequently are not present in court to dispute information that may not be trustworthy, it is important that the proceedings be conducted in such a manner as to ensure that only credible testimony is admitted into evidence. To the extent that judges conduct commitment proceedings according to rules of procedure and rule on objections according to rules of evidence, these concerns may be academic; however, to the extent that the attorneys fail to make objections, these concerns are significant.

Recommendation: Counsel for the state and for the respondent should strive to prevent the introduction of evidence that is in violation of the formal rules of evidence. When objectionable testimony is given over no objection, the court should alert counsel that rules of evidence should be followed.

11. The Question of the Respondent's Competency to Make Treatment Decisions

In some states, the court makes a finding during the commitment hearing concerning the respondent's competency to make treatment decisions once committed.[112] In states where involuntarily committed patients are accorded the right to refuse treatment once committed, such a determination can be useful. Although the law in North Carolina provides that a commitment shall in no way be taken as an adjudication of incompetency, it does not rule out the possibility that the question of incompetency could be heard and disposed of at the commitment hearing (so long, of course, as the requirements of the law governing the determination of incompetency were followed during the hearing). Whether such a procedure should be developed in Winston-Salem depends on the prevalence of incompetent treatment refusals in the mental health facilities.

12. The Presentation of a Treatment Plan

The criteria for involuntary commitment in a number of states require a showing that the respondent's debilitating condition is one for which appropriate treatment is available.[113] The United States

112. *See* PROVISIONAL SUBSTANTIVE GUIDELINES, *supra* note 8, at V-15 (1982).
113. *Id.* at IV-21.

Supreme Court has held that, at least with respect to persons committed on the basis of dangerousness to self, involuntary commitment without the administration of appropriate treatment designed to address the person's disorder is unconstitutional.[114] It is largely because of this right to treatment that the submission of a treatment plan at the commitment hearing is required in many states. The plan is intended to provide a basis on which the judge or other decision-making authority may determine the appropriateness of the treatment proposed and the likelihood that such treatment will bring about a desired change in the respondent's condition. However, it may be optimistic to think that a meaningful treatment plan can be constructed during a short prehearing hospitalization period. Because of this and because the local facilities as a matter of practice develop treatment plans for their patients within thirty days of admission and regularly update these plans during the period of hospitalization, the fact that treatment plans typically are not presented at hearings in Winston-Salem probably is of little significance.

13. The Role of Less Restrictive Alternatives

Statutes in a number of states provide that a court may not involuntarily commit anyone for whom a less restrictive alternative is appropriate.[115] Statutes in some states provide that, upon a finding of committability, the court must commit to the least restrictive program of treatment that is appropriate.[116] Statutes in other states do not address the question of less restrictive alternatives at all.

The failure of the statutes in North Carolina and the local procedures in Winston-Salem to specifically require that the court make commitment decisions in accordance with the least restrictive alternative principle is a weakness of the city's commitment system. Neither the interests of the respondent nor those of society are satisfied when treatment is imposed that is more intrusive and more expensive than is necessary to accommodate the respondent's disorder. Because North Carolina law requires treatment facilities to release involuntarily committed patients "as soon as a less restrictive mode of treatment is available," it would be absurd to suggest that the courts need not be bound by the least restrictive alternative principle in committing persons to these facilities.

Certainly, most of the judges in Winston-Salem, *in fact*, give some degree of consideration to the question of less restrictive alternatives when hearing commitment cases. Unless the court is required, before

114. O'Connor v. Donaldson, 422 U.S. 563 (1975).
115. PROVISIONAL SUBSTANTIVE GUIDELINES, *supra* note 8, at V-11.
116. *Id.*

ordering commitment, to make a finding that less restrictive alternatives were considered and that none was found to be appropriate, the question of less restrictive alternatives too easily is disregarded. Similarly, unless the court is required, before ordering inpatient treatment, to make a finding that involuntary outpatient treatment was considered and was determined not to be appropriate, the option of outpatient commitment too easily is overlooked.

Recommendation: Before ordering involuntary treatment, the court should consider whether any less restrictive alternative would be appropriate to accommodate the respondent's disorder and should make a finding that less restrictive alternatives were considered and none was found to be appropriate. Before ordering inpatient treatment, the court should consider whether involuntary outpatient treatment would be appropriate and should make a finding that outpatient treatment was considered and was found inappropriate.

In many jurisdictions, the state's attorney is required to investigate the appropriateness and availability of less restrictive alternatives and prove as part of his or her case that no less restrictive alternative to commitment exists.[117] Research suggests, however, that in jurisdictions with such requirements, the state's attorney often is unaware of the alternatives that exist in the community and conducts little or no meaningful investigation.[118] While this behavior is not to be excused, it does suggest that the state's attorney should not be solely responsible for investigating less restrictive alternatives. The best interests of the patient would be served if, in addition to and regardless of any responsibility that the state's attorney may have to investigate less restrictive alternatives, the respondent's attorney was required to assume this responsibility as well.

The fact that no one in Winston-Salem is responsible for developing and maintaining information for the court about community mental health programs available to function as less restrictive alternatives is a weakness of the Winston-Salem commitment system. Assigned counsel cannot be expected to be very familiar with such programs; but information about community treatment programs could be developed and maintained through the offices of the court and could be made available to assigned counsel on request. Professionals who are actively involved with the delivery of social services in the city can and should be called upon to assist in identifying community treatment programs and making appropriate information about these programs available to the

117. *See, e.g.*, VA. CODE § 37.1-67.3 (Supp. 1981).
118. J. ZIMMERMAN & W. FITCH, *supra* note 4, at 26.

court.[119] The information generated should be available at the courthouse for the use of prospective petitioners, respondents' attorneys, and judges.

Recommendation: The court, in collaboration with the local mental health association and other agencies, should develop and keep current information about treatment programs in the community that might be appropriate and available as less restrictive alternatives to involuntary hospitalization for respondents in commitment proceedings. It should be the responsibility of the respondent's counsel and the court to be familiar with this information and use it to identify the least restrictive treatment option that is appropriate and available for respondents.

The fact that the court does not frequently exercise the outpatient treatment option may be a weakness of the commitment system in Winston-Salem. One psychiatrist in Winston-Salem stated that he would recommend outpatient treatment much more frequently than he did "if the judges would ever order outpatient treatment." This psychiatrist suggested that, in many cases, inpatient care is not very useful because a patient's symptoms may rapidly remit because of medication and the patient may be quickly discharged, only to stop taking his or her medication and deteriorate to the point where further hospitalization is necessary. If judges would more often order outpatient treatment, he suggested, fewer cases would return to court because longer-term "maintenance" treatment could be provided.

The difficulty of enforcing the respondent's compliance with the terms of an outpatient treatment program is a serious problem to which there are no handy solutions. However, if the existing mechanisms for converting non-compliant involuntary outpatients to inpatient status were more frequently used, and if respondents receiving outpatient treatment were advised that non-compliance likely would result in such a conversion, the rate of compliance might rise.

One psychiatrist in Winston-Salem suggested that converting an involuntary patient from outpatient status to inpatient status was improper because the original outpatient order was based on a finding that outpatient, not inpatient, treatment was appropriate. However, insofar as every commitment order, whether inpatient or outpatient, is based on a finding that treatment is necessary (i.e., that the respondent is committable), it would seem reasonable to conclude at a supplemental hearing that if outpatient treatment failed because of the patient's unwillingness to cooperate, then outpatient treatment was *not* appropriate and inpatient treatment should be ordered.

119. The local Mental Health Association might be particularly well equipped to provide such assistance.

The reluctance of the court in Winston-Salem to use the "supplemental hearing" procedure to convert non-compliant involuntary outpatients to inpatient status may be ill-advised. If the court permitted the assistant district attorney responsible for original commitments in Winston-Salem to discharge the responsibilities placed by statute on the attorney general, it would seem that the supplemental hearing procedure would be *less* cumbersome than beginning a new commitment proceeding against the person. Indeed, the petitions, affidavits, and prehearing examinations required for initial proceedings would be replaced by two telephone calls—one from the director of the outpatient program to the district attorney and one from the district attorney to the clerk of the court. This procedure should prove to be less costly than beginning a new commitment proceeding and, because it is simpler to use, likely would be used more frequently. Moreover, to the extent that the procedure is useful, it should make outpatient treatment more attractive as a commitment option.

Recommendation: The assistant district attorney responsible for representing the state in commitment proceedings in Winston-Salem should be authorized to discharge the responsibilities imposed by statute on the attorney general in supplemental hearing proceedings to convert allegedly non-compliant involuntary outpatients to involuntary inpatient status. Further, the court should encourage staff of the treatment facilities providing involuntary outpatient care to use the supplemental hearing procedure to convert noncompliant involuntary outpatients to inpatient status.

14. The Court's Role in Determining Place or Conditions of Treatment

Some observers in Winston-Salem believe that the court should have the discretion to commit respondents for mandatory minimum periods of treatment. The clear majority, however, feel strongly that the courts should have no such discretion. Moreover, no one seriously suggests that the courts should have the authority to specify particular treatment modalities or other medical conditions of commitment. The law in North Carolina and the practice in Winston-Salem, leaving postcommitment treatment decisions in the hands of mental health personnel, are consistent with procedures in other states and seem to be entirely satisfactory.

V. POSTHEARING CONCERNS

For those respondents whose cases are dismissed at the hearing, the court's involvement ceases. For respondents who are committed to some form of treatment, however, the potential exists for legal

problems and court involvement throughout the commitment period. Under the authority of the court order, the facility to which the respondent is committed will attempt to exert its influence over the respondent's behavior; to the extent that the respondent resists the intentions of the facility, the question of "patients' rights" arises. This section discusses this question and others that may come to the attention of the court following the initial commitment hearing.

A. *Description*

1. Notification Requirements

If the court orders outpatient treatment, a copy of the order must be sent to the outpatient treatment facility designated.[120] No such notification is required if the respondent is hospitalized. If the court finds that the commitment criteria are not met, it must discharge the respondent and provide notification of the discharge to the facility in which the respondent was last a patient.[121] Mental health facilities to which respondents are committed are required by law to provide notification of discharge and conditional release to the clerk of the superior court of the county of commitment and of the county in which the facility is located.[122]

For the most part, notification of commitment or dismissal at the commitment hearing seems to be carried out in conformity with the prescriptions of statute. With regard to the requirement that mental health facilities notify the court of a committed patient's discharge, the research staff was told that "sometimes it's done, and sometimes it's not."

In addition to the notification of discharge required by statute, the facilities serving Winston-Salem often provide notification to members of the patient's family when discharge of the patient is imminent. A spokesperson at one of the facilities indicated that such notification always is provided unless the patient objects. A spokesperson at another facility indicated that such notification is not provided unless requested by the patient. When an involuntary patient is admitted to the John Umstead Hospital, staff at the facility reportedly ask the patient whether he or she will consent to communications from the facility to members of his or her family and staff of the community mental health center in the patient's community. If the patient expresses a wish that particular persons or agencies not receive information, the hospital notes these restrictions and honors them. If the patient imposes no re-

120. N.C. GEN. STAT. § 122-58.8(b) (1981).
121. *Id.* § 122-58.8(a).
122. *Id.* § 122-58.13.

strictions, notifications of the patient's discharge are sent to the patient's immediate family and to staff of the community mental health facility in the patient's home community.

2. The Right of Appeal

North Carolina law provides that respondents may appeal commitment decisions to the court of appeals. Appeals are heard on the record. The filing of an appeal does not stay the commitment, unless so ordered by the court of appeals.[123]

Appeals from commitment orders are rare in Winston-Salem, reportedly for two reasons: (1) appointed counsel consider their responsibilities to respondents essentially to cease at the conclusion of the commitment hearing, and (2) appeals typically are not heard until approximately six to eight months after they are filed, by which time most respondents can expect to have been discharged.

3. Institutional Activities

For the most part, the court's involvement with the mental health facility ends with the order of commitment. Mental health facilities in effect retain the right to accept or refuse to accept committed persons into their programs and, once accepted, to select and manage their treatment. Reportedly, the facilities serving Winston-Salem admit everyone committed by the court, presumably because the commitment typically is ordered at the recommendation of a physician on the staff of the admitting facility.

North Carolina law guarantees patients the right to treatment regardless of age or degree of mental illness or retardation.[124] The law also provides a right to be free from unnecessary or excessive medication with drugs and prohibits the use of medication as punishment or discipline.[125] Treatment involving electroshock therapy, the use of experimental drugs or procedures, or surgery (other than emergency surgery) may not be given without the written consent of the patient if competent.[126]

Mental health facilities in North Carolina are not required to provide periodic progress reports to the committing court, and the facilities serving Winston-Salem reportedly do not provide such reports.

North Carolina law provides that any interested person may petition the court for an order directing a committed patient transferred to another mental health facility. The court may issue a transfer order "if

123. *Id.* § 122-58.9.
124. *Id.* § 122-55.5.
125. *Id.* § 122-55.6.
126. *Id.*

such order is in the best interest of the committed person and the transfer conforms to the state policy of the least restrictive mode of treatment."[127] The law further requires that before a patient may be transferred, he or she (and his or her next of kin or guardian) must be given "reasonable written notice," which must include the reason for the transfer. Transfers for emergency surgery are excepted from the notice requirement.[128]

Transfers reportedly occur in Winston-Salem in three situations: (1) when a patient becomes so violent as to require hospitalization in a more secure facility; (2) when a patient's condition suggests that long-term care will be necessary; and (3) when the hospital bills for a patient at a private facility no longer are paid.[129] Transfers usually are to the John Umstead Hospital in Butner.

Although some hospital personnel in Winston-Salem admit an unfamiliarity with the procedures for transferring a patient, the assistant clerk of the superior court reportedly "takes care of the details" and ensures that transfers are accomplished in conformity with the law. By all accounts, transfer petitions routinely are granted. No one in Winston-Salem could recall a case in which a patient challenged a transfer. Indeed, no one was aware what procedure would be used to challenge a transfer.

The North Carolina statutes require that committed patients be discharged "as soon as a less restrictive mode of treatment is appropriate."[130] The statutes further require unconditional discharge at any time that the chief of medical services at a facility determines that a patient no longer is in need of hospitalization.[131] Committed patients may be released conditionally, for periods of up to thirty days, on specified conditions. Violation of the conditions is grounds for return of a person to the facility.[132]

Reportedly, involuntary patients in Winston-Salem are discharged unconditionally as soon as they improve to the point where they no longer meet the involuntary commitment criteria. According to hospital personnel, this almost always occurs before the expiration of the maximum commitment period ordered by the court. At the John Umstead Hospital, the statutory language requiring the release of involuntary patients "as soon as a less restrictive mode of treatment is appropriate" is interpreted literally; patients are released if they are

127. *Id.* § 122-81.2(c).
128. *Id.* § 122-55.6.
129. The private facilities reportedly will retain a patient at no charge for a limited period of time before either discharging or transferring the patient.
130. N.C. GEN. STAT. § 122-58.1 (1981).
131. *Id.* § 122-58.13.
132. *Id.*

suitable for a less restrictive mode of treatment, whether or not such mode of treatment is available.

The facilities in Winston-Salem rarely release patients conditionally, but the John Umstead Hospital in Butner frequently does. Although the law in North Carolina does not permit an institution to convert a patient from involuntary inpatient status to involuntary outpatient status, in effect this can be accomplished by conditional release. Personnel at the John Umstead Hospital recommend the use of the conditional release procedure for this purpose.

All of the facilities receiving persons committed from the district court in Winston-Salem reportedly provide discharge planning services of one kind or another. Discharge planning typically includes contacting members of the patient's family who might be willing to offer the patient a place to live and attempting to arrange for the patient's participation in a community services program on a voluntary basis. Everyone in Winston-Salem notes sadly that community programs are too few.

4. Patients' Rights

In addition to the rights of patients to be treated and to be free from particular types of unwanted treatment, basic human rights are recognized by statute in North Carolina, including rights to dignity, privacy and human care, and the right to live as normally as possible while receiving care and treatment.[133] Other more specific rights also are recognized, including rights to send and receive mail, make and receive confidential telephone calls, keep and use personal clothing, and exercise all civil rights, including rights to dispose of property, execute instruments, make purchases, enter into contractual relationships, register and vote, and marry and divorce (if not adjudicated incompetent).[134] Reportedly, all of these rights are accorded to involuntary patients at the local facilities and at the John Umstead Hospital in Butner.

As discussed previously in the Counsel section, the attorney assigned to represent an indigent respondent at the initial court hearing ordinarily remains statutorily responsible for the respondent's representation until the respondent is unconditionally discharged, if commitment was to a community mental health facility. Nevertheless, assigned counsel in Winston-Salem reportedly consider their responsibilities to cease at the conclusion of the commitment hearing. Consequently, indigent respondents committed to community facilities are provided with no legal representation during the commitment period. The Mandala Center in Winston-Salem employs a non-attorney patient's ombudsper-

133. *Id.* § 122-55.1.
134. *Id.* § 122-55.2.

son, who is responsible for investigating patients' grievances. This ombudsperson reportedly spends approximately one-third of her time doing ombudsperson work; the balance is spent doing public relations work for the hospital.

Respondents committed to the John Umstead Hospital in Butner are represented post-hearing by a "special counsel" who is appointed by the senior regular resident superior court judge of the judicial district in which the John Umstead Hospital is located. In addition, the hospital employs a non-attorney patient advocate who is responsible for investigating patients' grievances and bringing legitimate complaints to the attention of the hospital's human rights committee. The advocate investigates allegations of patient abuse, neglect, and exploitation and consults the special counsel if she has a question about the appropriateness of a particular commitment.

5. Rehearings

The North Carolina statutes provide that the initial commitment period may not exceed ninety days.[135] Inpatient commitment may be extended by a rehearing procedure,[136] but outpatient commitment may not be extended.[137] If the chief of medical services of an inpatient facility determines that treatment of an involuntary patient will be necessary beyond the initial commitment period, he or she may notify the clerk of the superior court of the county in which the facility is located at least fifteen days before the end of the period. At least ten days before the end of the period, the clerk must schedule a rehearing and notify the patient and his or her counsel of the time and place of the rehearing. Rehearings are held at the facility in which the patient is receiving treatment.[138] Rehearings are governed by the same procedures as initial hearings, and the patient has the same rights as he or she had at the initial hearing, including the right to appeal. A patient found to continue to meet the commitment criteria may be recommitted for a period not to exceed 180 days.

With regard to further rehearings, the law[139] dictates certain requirements. Fifteen days before the end of the second commitment period, and annually thereafter, the chief of medical services of the facility must review the condition of each involuntary patient; if he or she determines that a patient is in need of continued treatment, he or she may so notify the patient, the patient's counsel, and the clerk of the superior

135. *Id.* § 122-58.8(b).
136. *Id.* § 122-58.11.
137. *Id.* § 122-58.11(f).
138. In the rare case in which someone committed to one of the facilities in Winston-Salem is scheduled for a rehearing, the rehearing is held in a courtroom at the Hall of Justice.
139. N.C. GEN. STAT. § 122-58.11 (1981).

court of the county in which the facility is located. Unless the respondent, through his or her counsel, files with the clerk a written waiver of the right to a rehearing, a rehearing is scheduled and held in the same manner as initial rehearings are scheduled and held. Recommitment may be ordered for up to one year.

Rehearing practices in Winston-Salem and at the John Umstead Hospital in Butner reportedly conform essentially with the procedures prescribed by statute.

B. *Strengths, Weaknesses, and Recommendations for Improvement*

1. Notification Requirements

The notification requirements imposed by statute in North Carolina seem reasonable. However, the absence of any requirement that notification of the respondent's commitment to or discharge from a treatment facility be given to the respondent's next of kin, guardian, or other relatives, or that the hospital or the court refrain from notifying particular individuals whom the respondent indicates he or she does not want notified, suggests avenues for possible improvement. Because of the concern that families typically have for the whereabouts of their mentally disabled members, it is advisable that a notification policy be developed. Whether the respondent should be permitted to prevent notification of particular persons is a difficult question, particularly if the respondent's competence to make such decisions is questionable. However, most observers in Winston-Salem agree that the respondent's wishes in this regard should be respected.

Recommendation: It should be the responsibility of staff of the facility in which the respondent is committed to inform the respondent of his or her right to have family members and others notified of the commitment and of any subsequent discharge. Staff should explain to the respondent that unless he or she objects, the next of kin or guardian will receive such notification. If the respondent expresses a wish that particular persons not receive notification, the facility should refrain from notifying such persons unless required by law to do so.

2. The Right of Appeal

It is important that appeals be available to persons committed to involuntary treatment, not only to allow for the review of particular cases, but also to allow for the settling of points of law interpreted differently by different judges. The practical impediments to appeal for persons committed in Winston-Salem, i.e., the unavailability of counsel for indigents and the slowness of the appellate process, are serious weaknesses in the city's commitment system.

Recommendation: Immediately following an order of commitment, the respondent's counsel should explain to the respondent his or her right to appeal and should be available to pursue an appeal for the respondent if the respondent so desires and there is a legitimate ground for appeal. The judges of the district court, together with the judges of the court of appeals, should develop a policy for compensating appointed counsel pursuing an appeal on the respondent's behalf. The court of appeals should maintain an expedited calendar for commitment appeals.

3. Institutional Activities

The statutes in North Carolina regulating the institution's treatment of committed persons are exemplary. The specification of a right to treatment serves to guard against the patient "warehousing" that was common at many hospitals throughout the country in past years. The mandate that medication not be used for punishment or discipline also is important, given the ease with which medication can be misused for patient management. The lack of a provision in the law or a consistent policy in the local facilities for dealing with patients who refuse medication is a weakness in the commitment system.

Most observers in Winston-Salem believe that, because the court does not participate in treatment or release decisions, no useful purpose would be served by requiring treatment facilities to provide periodic reports concerning the progress of committed persons. Furthermore, the time spent preparing and submitting such reports would reduce the availability of facility personnel to treat patients.

The procedures used to transfer involuntary patients from one facility to another are not the subject of great concern in Winston-Salem. However, because the transfer process as it is used in Winston-Salem typically operates to move someone from one of the local facilities to the regional hospital in Butner (arguably a more restrictive setting, if only because it is outside of the patient's community), the case can be made that the patient should be provided with an opportunity to challenge the transfer in court.

Recommendation: A copy of the petition for transfer should be served on the patient and the patient's counsel at least forty-eight hours prior to the proposed transfer. The patient should be given a right to a hearing, on request, to challenge the petition for transfer before a judge of the district court within the forty-eight hour period. Notice of this right should be provided to the patient and the patient's attorney with the petition. The patient's attorney should be responsible for representing the patient at the hearing, if one is requested. If the patient is not represented by counsel,

counsel should be appointed. The judges of the district court should develop a policy for compensating appointed counsel for this representation.

The conditional release provision is a strength of the North Carolina commitment procedure because it allows a mental health facility to work with and retain some control over a patient during his or her period of readjustment to community living. Because it allows the facility to recall a patient whose readjustment is unacceptable, it encourages facilities to try an earlier return to the community of patients whose prognoses are improved but still imperfect. The John Umstead Hospital in Butner reportedly makes excellent use of the conditional release procedure. That the facilities in Winston-Salem rarely use the procedure is a weakness in the city's commitment system.

Recommendation: Persons responsible for discharge planning at the facilities in Winston-Salem should more frequently consider conditional release as a discharge option.

The efforts of the facilities serving Winston-Salem to refer released patients to community services programs are to be commended. It is unfortunate, however, that so few programs exist. The legal and mental health communities in Winston-Salem should work with local foundations and others interested in supporting the development of such programs.

4. Patients' Rights

The law in North Carolina provides for the protection of the human rights of committed persons. Given that mental institutions through the years have acquired a poor reputation in this regard, this statutory concern for patients' rights in North Carolina is to be commended. The impressions of the research staff, based on visits to institutions serving Winston-Salem, were that these facilities protect the rights of patients to an unusually high degree. Meaningful programs of treatment seem to be available, and living conditions seem relatively pleasant.

The statutory recognition of an involuntarily committed patient's right to legal representation during the commitment period is a strong feature of the commitment law in North Carolina. The ordinary affairs of life that require the assistance of an attorney, e.g., marriage, divorce, and bankruptcy, do not cease during commitment; rather, a host of new legal problems typically arises. To the extent that the legal representation prescribed by statute is not reflected in practice, the commitment system suffers.

The use of special counsel to provide continuing legal representation for patients committed to the John Umstead Hospital in Butner is an

excellent aspect of North Carolina practice. That hospital's use of a patient advocate to respond to patient grievances and refer appropriate problems to the special counsel seems to result in an effective patient protection system. In contrast, the failure of appointed counsel in Winston-Salem to provide continuing representation for persons committed to the local facilities violates the law and may seriously diminish the patient's ability to protect his or her legal interests while hospitalized. The employment of a part-time ombudsperson at the Mandala Center is to be commended, but it should not be regarded as a satisfactory substitute for the provision of legal assistance.

Recommendation: Unless a system is developed in Winston-Salem whereby special counsel are designated to be responsible for representing patients committed to the city's inpatient facilities, counsel assigned to represent the respondent at the initial hearing should be required to remain responsible for the respondent's representation during the commitment period (as required by law).

5. Rehearings

The rehearing procedures prescribed by statute in North Carolina seem fair. Because rehearings are relatively rare in Winston-Salem, however, little is known about how these procedures work. The only issue raised by observers in Winston-Salem concerning the rehearing process deals with the exclusion of persons of outpatient status from the rehearing procedure. Because of the great potential of the involuntary outpatient device for the long-term, minimally restrictive care of the chronically mentally ill, it makes little sense to limit outpatient commitment to one ninety-day period.

Recommendation: A statutory amendment should be sought making the rehearing procedure applicable to persons of involuntary outpatient status.

VI. Conclusion

Civil commitment laws provide merely the skeleton of civil commitment systems. The vital functions are better represented by the practices, customs, and mores of the people who are responsible for implementing these laws in the community. Civil commitment reform that fails to take this into account is of limited value.

This Article has focused on the everyday workings of the civil commitment system in Winston-Salem, North Carolina. It has examined in some detail the means employed in the city to implement the state's commitment laws and has presented a practical analysis of what works

well and what does not. By focusing on these successes and failures, policy-makers in Winston-Salem have an excellent opportunity to effect meaningful reform in their city's civil commitment system.