# INVOLUNTARY CIVIL COMMITMENT IN WINSTON-SALEM

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# CHAPTER I. ACKNOWLEDGEMENTS

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The management, staff, and Board of Directors of the National Center for State Courts must be acknowledged for their contributions to this project as well. Mr. Edward B. McConnell, Executive Director of the National Center, is responsible for the project's conception. Professor Anthony L. Guenther of the College of William and Mary, working as a consultant to the National Center, refined the concept and developed the idea for a field research project. Members of the National Center's Board of Directors reviewed the project idea and commented on it from the perspective of judges. National Center library staff provided enormous aid in locating and acquiring reference materials throughout the project period.

In the early phases of the project, the research staff received substantive guidance from a remarkably informed group of people known collectively as the National Advisory Board. These people helped define the critical research questions, sharpen the project goals, and develop research methods. Their names and affiliations follow:

Chairman
Honorable Joseph Schneider
Illinois Circuit Court of Cook County
Chicago, Illinois

Professor David B. Wexler
University of Arizona
College of Law
Tucson, Arizona

Mr. Paul Friedman
Ennis, Friedman, Bersoff and Ewing
Washington, D.C.

Dr. Paul Appelbaum
Law and Psychiatry Program
University of Pittsburgh
Pittsburgh, Pennsylvania

Mrs. Helen Wright
Washington, D.C.

Professor B. James George, Jr.
New York Law School
New York, New York

Mr. Richard P. Lynch
American Bar Association
Washington, D.C.

A special advisory group was assembled in the City of Winston-Salem. These advisors provided detailed information about the city's legal and mental health systems and identified people who were of central importance to the functioning of these systems. The Winston-Salem advisory group was composed of these individuals:

Chairperson
Honorable Gary B. Tash
North Carolina District Court,
Twenty First Judicial District

Ms. Anne Compere
Director, Mental Health Association

Mr. Larry Counselman
Assistant Clerk, Clerk of Superior Court Office

Ms. Beth Glass
The Winston-Salem Foundation

Dr. George Hamilton
Director, Forsyth-Stokes Community Mental Health Center

Ms. Mary Jean Hayes
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Mr. Victor Lefkowitz
Attorney-at-Law

Ms. Barbara Muse
Assistant Director, Mental Health Association

Dr. Selwyn Rose
Salem Psychiatric Associates

Ms. Ann Ryder
State Department of Human Resources
Division of Mental Health and Mental Retardation

During the field work in Winston-Salem, many individuals helped explain and demonstrate the workings of the city's commitment system. Some of these people must go unnamed -- the patients, secretaries, clerks, family members, and others who simply acted naturally and allowed us to observe as they played their parts in the system. Individuals who generously gave of their time for personal and group interviews include:

Dr. Selwyn Rose
Salem Psychiatric Associates

Dr. George Hamilton
Director, Forsyth-Stokes Community Mental Health Center

Honorable Gary B. Tash
North Carolina District Court,
Twenty First Judicial District

Honorable David R. Tanis
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Ms. Anne Compere
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Mr. Lyn P. Burleson
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Mr. Victor Lefkowitz
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Ms. Barbara Muse
Assistant Director, Mental Health Association

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State Department of Human Resources
Division of Mental Health and Mental Retardation

Sergeant Jerry Raker
Winston-Salem Police Department

Officer Alison Butts
Winston-Salem Police Department

Officer Steve Hutchinson
Winston-Salem Police Department

Captain J.A. Landon
Winston-Salem Police Department

Mr. Dan Johnson
Graham, Crumpler, & Habegger

Dr. Dietrich Heyder
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Mr. John Hauber
Forsythe Memorial Hospital

Mr. S. Mark Rabil
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Ms. Bebie Cole
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Dr. Henry Burton
John Umstead Hospital

Mr. Wilson Hayman
John Umstead Hospital

Ms. Laura Finks
John Umstead Hospital

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Points of view, opinions, and recommendations advanced in this report are those of the project staff only. They do not represent official policies or positions of the National Center for State Courts; the agencies that helped fund this research; the court systems affiliated with Winston-Salem, North Carolina; the North Carolina Department of Human Resources, Division of Mental Health and Mental Retardation Services; the Winston-Salem advisory group; or any of the individuals who participated in this research or the organizations with which they are affilitated. The author gratefully acknowledges the contributions made by these people and organizations. However, all responsibility for factual errors made or opinions expressed in this report rests with the author.

# CHAPTER II. INTRODUCTION

## Organization and Purpose of the Research Project

The research performed in Winston-Salem was part of a larger research effort undertaken by the National Center for State Courts. The research project began on January 1, 1981 and lasted for one year. Funding for the project was provided by a coalition of foundations. The major funding base was a grant from the John D. and Catherine T. MacArthur Foundation of Chicago ($100,205). Additional grants were made to enable local site participation: The Winston-Salem Foundation ($15,489); The Chicago Community Trust ($16,385); The Columbus Foundation ($15,010); and The New York Community Trust ($16,700).

Five major products were to result from this research: reports examining commitment procedures at each of the four project sites, and a nationally-oriented judge's guide presenting suggested procedures for the implementation of commitment laws in courts throughout the country. All of the information generated by the project was to be pragmatic and utilitarian. Site reports were intended to focus primarily on the manner in which a local commitment system functions. Observations were to be made of how statutory provisions were implemented, where and why practice deviated from statute, and what practices had been developed to address problems not anticipated by statute. Strengths and weaknesses were to be analyzed and recommendations for change and improvement were to be made. The judge's procedural guide also was to be pragmatically oriented, but with a national perspective. It was to be a comprehensive review of how different states approach the problems of civil commitment, with commentary about which approaches seem to work best. The end product was visualized roughly as a set of procedural standards with commentary.

A second major phase of the project was envisioned for 1982 and 1983, contingent upon the receipt of additional funding. During a second phase project, the primary activity would be dissemination of information rather than research. This would be accomplished through the establishment of a civil commitment information clearinghouse, wide dissemination of the judge's guide, a series of seminars and workshops for judges and other court and mental health personnel, and technical assistance to local courts and social service agencies interested in improving their commitment systems.

## The Winston-Salem Report

This report focuses on the system of involuntary civil commitment in Winston-Salem, North Carolina. It will begin with an explanation of how the research was conducted, what its limitations are, and how certain terms are used.

## A. THE NATURE OF THE ANALYSIS

This document is a descriptive and qualitative analysis of the laws and procedures relating to the involuntary civil commitment of adults in Winston-Salem. The bases for the analysis are the North Carolina statute and relevant case law, professional literature in law and mental health, interviews with people who work in the Winston-Salem system, and observations of the system at work.

Although the report contains many references to the North Carolina statutes, it is not intended as either a definitive legal analysis of those statutes or an exhaustive descriptive analysis. Reference is made to the statutes to help explain why and how the system works as it does in Winston-Salem. Interpretations of statute presented in this report should not be taken as authoritative, whether presented as the interpretations of these researchers or of people in the field.

Neither is this report to be taken as a scholarly analysis of issues. It contains no citations to professional literature, although an enormous body of relevant literature exists. Scholarly works abound on mental health law and civil commitment, including some produced by the staff of this project. (For example, see "Involuntary Civil Commitment: The Discerning Eye of the Law," State Court Journal, 1981, 5(4), 5ff. Copies are available from the National Center for State Courts.) To cite professional literature as it relates to the manifold aspects of this report would have been an enormous task and would have increased the bulk of this report significantly. We thus chose not to cite these works, leaving scholarly analyses to other reports in which they already have been done quite well. Our obvious debt to the scholarly work of others in this field is readily acknowledged, however, and will be easy to identify in the pages that follow. We make no pretense that the philosophical and technical ideas raised in this volume are original thoughts, and we apologize in advance to the numerous authors whom we fail to credit.

Then what is this report? This report describes how informed people who are involved with commitment cases in Winston-Salem perceive their system to work. It is a report of what these people do, what they feel about what they do, and what they have suggested about other ways their work might be done. While we do not claim to present an authoritative treatise on either the law or current scholarly thinking in this area, we do hope to present an accurate and representative report of the opinions and practices of the people who are central to the Winston-Salem civil commitment system.

All that we know about the system is what we have been told by the people in Winston-Salem, supplemented by the statutes, the professional literature, and a limited number of personal observations. When it is reported that certain events occur in Winston-Salem, it should be understood that this means we were told that those events occur or that we observed them occur. If specific sources of information are not

cited, it can be assumed that this information was reported to these researchers by virtually everyone who was interviewed. If information came only from a particular source, or if it differed from information coming from other sources, then the specific source of the information is identified. All information sources are reported as generic categories of people, such as judges, attorneys, physicians, mental health professionals, and so on. Specific names of people are not used. We have attempted to maintain confidentiality of the information that was provided to us. We promised that names would be removed from all data materials so that particular persons could not be associated unambiguously with particular bits of information provided to us.

Appendix B contains copies of the data collection guides that were used by researchers in Winston-Salem. The appendix also contains a statement of research ethics and confidentiality that directed this work. A complete set of field notes, with names of people removed, can be obtained from the National Center for State Courts.

The analysis is organized roughly chronologically, proceeding from prehearing events, through the hearing, to posthearing concerns. A separate section is included regarding the respondent's counsel, who usually comes into the picture after a person has been taken into custody but before a hearing, and whose involvement may last through the posthearing period. While another means of organizing these materials might arguably have been more effective, this general organization scheme was used in order to provide maximum comparability between these materials and those that the project staff prepares for other sites and for general use.

The report and its recommendations have been reviewed by many people in Winston-Salem. In addition to serving the project in the capacity of advisors and data sources, the individuals whose names are listed in Chapter I were given the opportunity to review the report, correct errors, and suggest revisions in the recommendations. No topic of this complexity can generate a perfect unanimity of opinion, however. Differences in perceptions are acknowledged in the report as much as possible. When conclusions or recommendations had to be fixed in one direction or another, though, the final decisions were made by research staff and it is they who must be accountable for whatever degree of wisdom or folly was thereby created.

## B. LIMITATIONS

Every research effort has its limitations. These need to be acknowledged so that the conclusions in the report are not generalized to situations to which they do not apply.

This report applies only to the process of civil commitment in the City of Winston-Salem. It is not meant to apply to any other parts of the State of North Carolina, or even to Winston-Salem's nearby suburbs. Some parts of the information certainly will generalize beyond

the City; but generalizations to other areas must be made by the reader as fortuitous and serendipitous offshoots of this work, not as the intention of these researchers. Other products coming from this research project will establish some general lessons that might be applied nationwide, but that will not be the intent of this report.

This report relates only to mentally ill adults in the civil justice system in Winston-Salem. The report is not meant to be accurate with reference to prisoners, juveniles, or the mentally retarded or developmentally disabled, except where noted.

The data for this report were gathered during October 1981. The final report was released in February 1982. The report is accurate as of that time. In performing policy analysis and making recommendations for change, one implicitly hopes that the report soon will be out of date. The longer a situation remains unchanged, the longer the report contents remain accurate and the greater the evidence that the report had no impact.

## C. TERMINOLOGY

Some terms used throughout this report deserve special comment. These will be noted here and will not be repeated as the terms are used.

The most important term requiring discussion is the word "commitment" and its various forms and derivatives. The current vogue is not to use this word because of its strong negative connotations. In its place, many people are using the term "hospitalization." We have chosen, though, to use "commitment" in this report for two reasons. First, it is a term that is commonly used in speech, readily recognized, and well understood. Second, in North Carolina and several other states, commitment and hospitalization are not synonymous. Hospitalization is merely one form that an order of commitment may take. Commitment is more nearly synonymous with "court-ordered treatment." While the term "court-ordered" might be a good substitute term for "committed" in North Carolina, statutes in other states make it possible for people to be committed without the involvement of a court. Thus, the search for a synonym is frustrated and the choice is made to use the word "commitment" despite the stigma that has been associated with it. Perhaps the ultimate solution to this problem will be reform of civil commitment law and mental health practices, and subsequent re-education of the public, so that the stigma, and not the word, eventually disappears.

Two other words appearing throughout this report are "respondent" and "patient." These words are essentially synonymous for the purposes of this report. Technically, a patient is a person who has been admitted for mental health treatment, with or without court involvement, as either an inpatient or an outpatient. (Outpatients are more frequently referred to as "clients" by mental health professionals, but they will be called "patients" in this report.) A respondent is a person who is the subject of an involuntary commitment proceeding. Generally, the report refers to the person as "respondent" with regard to

legal concerns and before a commitment has been ordered. The person is referred to as a "patient" with regard to treatment concerns and following a commitment or voluntary admission to treatment.

Another term frequently used in this report is "these researchers." Associated terms are "we," "project staff," "our," and so on. These terms refer to staff of the National Center for State Courts who participated in this research project. They are listed by name in Chapter I. The project benefitted immensely from the staff's sharing of observations, ideas, and opinions. As a result of the sharing process, however, it is impossible to place responsibility for any of the report's contents with any single individual. Larry Fitch served as primary author of this report, however, and it is he who bears responsibility for the accurate chronicling of this material.

Throughout this report, reference is made to "the North Carolina statutes," or simply "the statutes." These statutes are contained in the North Carolina Mental Health Laws (N.C. Gen. Stat. §122-1 Et. Seq. (1981)).

# CHAPTER III. METHODOLOGY

This chapter presents a discussion of the project methodology. It considers methods for the national project as well as for the project work specific to Winston-Salem.

## Literature Review

In January 1981, the project staff began collecting and reviewing professional literature in the psycho-legal area. Source materials were collected from books and journals in the disciplines of law, psychiatry, psychology, social work, sociology, and public policy administration. Professors and mental health practitioners throughout the country were contacted and informed about the project and asked to provide copies of papers and other hard-to-find writings pertaining to involuntary civil commitment. Members of the project's National Advisory Board were particularly helpful in steering project staff to valuable reading materials.

Just prior to a meeting of the National Advisory Board in April, staff prepared an "Issues Paper" summarizing the relevant literature and defining important contemporary issues of civil commitment with which this project was to be concerned. The substantive portion of the "Issues Paper" has been altered slightly and published as "Involuntary Civil Commitment: The Discerning Eye of the Law" (State Court Journal, 1981, 5(4), 5 ff.), copies of which are available from the National Center for State Courts Publication Department. At their meeting, members of the National Advisory Board helped staff decide what research questions should be explored during site visits and gave counsel on field research methods.

## Statutory Review

By identifying the important questions that might be addressed in a commitment statute and then ordering them roughly as they might become relevant in a typical commitment proceeding, a scheme was devised for analyzing civil commitment statutes. A complete statutory analysis was performed for 20 states, including the states in which the National Center's project had received funding to conduct site-specific research and states that had been brought to the staff's attention as having statutes that were particularly interesting, innovative, or modern. Using the analytical scheme that had been developed, staff compiled all the variations of statutory provisions relating to each of the analytical categories and determined where and how commitment statutes and

procedures differed from state to state. These points of difference became the focus for the field data collection.

## Preliminary Site Visits

A preliminary visit was made to each of the four project sites. Three project staff visited Winston-Salem on April 6 and 7. During this visit, they met with individual members of the Winston-Salem Advisory Board and with the Board as a group. Advisory Board members gave staff their perceptions of how the Winston-Salem commitment system works and noted problems with the system and peculiarities that set it aside from most others. Most importantly, Board members identified the agencies and institutions in Winston-Salem that are involved in civil commitment cases. Key people within these organizations were named, as were other people unrelated to major institutions but important or knowledgeable in the commitment area. Advisory Board members' names are listed in Chapter I.

## Site Visits

After completing the comparative statutory analysis, staff made intensive data collection trips to each of the four project sites. Four staff members travelled to Winston-Salem during the week of October 5-9.

During the two weeks prior to the site visit, intensive preparations were made. Individuals who had been identified during the preliminary site visit as important or knowledgeable in the commitment area were contacted by telephone and interview appointments were scheduled. Staff thoroughly reviewed the North Carolina statutes and case law and identified questions of particular concern for the Winston-Salem system. Interview guides were mailed to people who were to be interviewed so that they could review the areas of concern in advance and prepare for the interviews if they wished to.

Most site participants were interviewed individually, although some were interviewed in groups. With very few exceptions, all interviews were conducted by two or three staff researchers. Prior to each interview, one researcher was assigned the role of "scribe." The scribe's duty was to record the interviewee's responses, while another researcher attended carefully to substance and led the interview.

All court hearings conducted during the time that staff visited the site were observed. An observation guide was prepared and studied in advance of the hearings. (The observation guide for Winston-Salem is contained in Appendix B.) Notes taken during interviews and court hearings generally were in a rough, "scribbled" form. Each staff researcher rewrote his or her notes during the week following the site visit.

While in Winston-Salem, staff met at the end of each day to compare notes and impressions about the city's commitment system. Key concerns were whether information received from various sources was in agreement and whether information in particular substantive areas was complete. Based upon these discussions, interview assignments for the next day were made. When staff were confident of the information they had received on a particular topic, no further questions were asked on that topic.

The names of people who were interviewed in Winston-Salem are listed in Chapter 1. These individuals were chosen on the basis of their involvement in commitment proceedings in the city. An effort was made to interview at least one representative from each facility and agency having contact with commitment respondents. These individuals were not intended to constitute a statistically representative sample in any sense. Furthermore, the research was not intended to establish what is average or typical or what the typical person thinks about the commitment system in Winston-Salem. Rather, it was to gain insight into how the system works and how it might be made better, from the perspectives of special people with extraordinary abilities to understand and comment on it.

## The Form of the Data

The ultimate goal of this research project was to generate information that could be used to help improve civil commitment procedures in jurisdictions throughout the country. The purpose of the data collection was to obtain practitioners' opinions, advice, and suggestions about the civil commitment process, particularly as it operates in their own localities. Accordingly, it was appropriate that the research be qualitative rather than quantitative. Our main purpose was not to ask how many, or even how; rather it was to ask why, how well, and how else. Basically, we sought information about what works best and why.

The questions in the data collection guide were open-ended. Multiple-choice types of questions were avoided so that interviewees would be free to formulate their own opinions without having their thoughts slotted into predetermined categories by the researchers.

The data collection guide (continued in Appendix B) is a complete set of the questions that were asked. The interview guide covers many topics and flows, more-or-less, in chronological order, as events occur during a typical commitment proceeding. The questions unavoidably overlap to some degree, but repetition was minimized as much as possible.

Because of the length of the data collection guide, not every question was asked of every interviewee. A subset of questions was presented in each interview to optimize the match of the interviewee's special area of knowledge with the questions asked. Everyone, however, was invited to discuss any aspect of the commitment process with which he or she was familiar or about which he or she had particular opinions or suggestions. Interviewers were able to (and frequently did) stray from the planned path of questions when it seemed useful and appropriate.

The questionnaire was considered only a data collection guide, not a dictum. Neither the precise language of the questions nor the order in which questions were asked was considered to be important. The guide was simply a reminder of important issues and ideas that needed to be discussed. More concern was given to understanding responses than to recording them thoroughly or verbatim.

A complete set of field notes, with all names and personal identifiers removed, is available from the National Center for State Courts. It will be provided upon request for the cost of duplication and mailing.

## Analysis, Report, and Review

A qualitative content analysis was performed on the data collected. Interview and observation notes first were reviewed and cross-referenced. Note was made of topics of significance, points of agreement among interviewees, and points of disagreement. For each topic of concern, the analysis covered the statutory provisions, the practices at the site, and commentary about the statutes and the practices.

Three major criteria are used in this report to evaluate the civil commitment system in Winston-Salem: legal protections, provision for treatment, and social benefits. That is, each procedure is analyzed in terms of how well it protects the legal (e.g., liberty) interests of respondents, how well it provides for respondents' treatment needs, and how well it accommodates the interests of society (e.g., safety, public health, minimum cost). The judgments of how to apply these criteria to elements of law and practice fell to these researchers, based upon their knowledge of the literature, their observations, and their discussions with practitioners. The reader is free, of course, to disagree with this analysis and may choose to view the system's strengths and weaknesses from a different perspective.

The results of the analysis assume the form of recommendations for improvement in the city's civil commitment system. The recommendations should not be taken as research conclusions or empirically proven statements of fact. Rather, they are the suggestions of these researchers, based upon their studies and points of view. As explained in Chapter V, the recommendations derive from a variety of

sources: suggestions made by people in Winston-Salem, suggestions made by people in other cities, conclusions from the professional literature, and ideas generated by the researchers during the course of the project. It would be impossible to sort out the influence of these various sources on any recommendation or to report accurately how extensive any person's or group's agreement would be with any particular recommendation.

The purpose of presenting recommendations is to highlight certain problems and alert people in Winston-Salem to possible solutions. Although it is easy for us to identify a problem, we are too far removed from the system to be expected to have "The Answer." A more realistic objective is to present "an answer," however modest and tentative, as a stimulus and starting point for thoughtful consideration by those who know Winston-Salem's system better and are in a position to make appropriate changes.

Drafts of the site reports were reviewed first by project staff and then were distributed to people in the respective cities for review and comment. The Winston-Salem report was sent for review by all members of the Winston-Salem Advisory Board and by all individuals who had participated in the data collection effort. Everyone receiving a review draft was invited to make suggestions for change and was urged to correct any statements that were factually incorrect. A meeting was held with the Winston-Salem Advisory Board and all others who had participated in the data collection effort to review this draft as a group.

Reactions from these people were taken into account in preparing the final text. (Written comments received from this group are included in the raw data materials available from the National Center.) As a result of their comments, several portions of the text were corrected and modified and a number of the recommendations were altered. It should not be inferred, however, that this report or its recommendations have been adopted officially by the Winston-Salem advisory group or that the group had a singular concurrence of opinion on all the issues raised in this volume.

# CHAPTER IV. OVERVIEW OF THE NORTH CAROLINA SYSTEM FOR TREATING THE MENTALLY ILL

## Purpose

This chapter begins with a thumb nail sketch of the North Carolina system for treating the mentally ill. It should help the reader understand subsequent chapters of the report by providing a general review of the state's treatment system without getting into fine detail. While the overview in this chapter is generally accurate, it should be considered neither exact nor complete. Precision has been sacrificed for the sake of clarity and brevity.

The overview is a blend of both what is required by statute and what happens in practice. The implementation of the civil commitment law in North Carolina, as in most other states, is not precisely what one would expect from a literal reading of statutes. While most statutory provisions are adhered to in Winston-Salem, some are not. More importantly, the Winston-Salem system has evolved procedures for working through problems and dealing with situations that are not addressed specifically by statute.

The focus of this report is on how the treatment system in Winston-Salem operates, in fact. Reference is made throughout the report to how the system is supposed to operate (according to statute) and how it otherwise might operate (according to recommendations); but every discussion contained in this report begins with a description of what is actually happening in the system, for this represents the point from which any reform effort must progress.

## Going Through the System

The General Statutes of North Carolina provide for two routes of access to psychiatric treatment: voluntary admission to a treatment facility and involuntary commitment to inpatient or outpatient treatment. (Although not provided for by statute, anyone is free to seek voluntary treatment on an out-patient basis, as well.)

Anyone seeking voluntary admission to a treatment facility may present himself or herself to the facility for evaluation. The prospective patient must complete an admission application, which includes an acknowledgement that he or she may be held by the facility for up to 72 hours subsequent to any written release request he or she might later make. (This 72-hour hold is designed to enable the facility to initiate involuntary civil commitment proceedings against any patient requesting release but meeting the involuntary commitment criteria.)

Within 24 hours of the person's arrival at a treatment facility, a physician must evaluate the person and determine whether he or she is in need of treatment for mental illness or inebriety. If the physician determines that the person is in need of such treatment, the person will be accepted as a patient; otherwise the person will be denied admission.

The involuntary civil commitment process in North Carolina may be initiated by any person (petitioner) having knowledge of another (respondent) 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. The petitioner executes an affidavit to this effect and petitions a clerk of a superior court or a magistrate of a district court for an order to have the respondent taken into custody for examination by a "qualified physician." If the clerk or magistrate finds "reasonable grounds" to believe the petitioner's allegations and determines that the respondent probably meets the commitment criteria, he or she issues a custody order and arranges for the order to be picked up by a law enforcement officer.

The officer receiving the order takes the respondent into custody and delivers him or her to a community mental health facility for evaluation. (In Winston-Salem, respondents may be taken to one of the local, private facilities if the petitioner is willing and able to arrange for this.) If a qualified physician is not available at the facility, the officer may take the respondent to a qualified physician available locally. If no qualified physician is available locally, the officer may detain the respondent in the respondent's home or at a hospital, clinic, or mental health facility (but not in a jail or penal facility) until a local physician is available. (In Winston-Salem, virtually all initial evaluations are conducted in one of the city's inpatient facilities.)

After examining the respondent, if the qualified physician concludes that the respondent does not meet the commitment criteria, the respondent is released and the proceedings against him or her are terminated. If the physician finds that the respondent meets the criteria, the officer takes the respondent to a community mental health facility (or to a regional psychiatric institution if no such facility is available) for temporary, inpatient custody and observation pending a court hearing. (In Winston-Salem, because the initial evaluation ordinarily is conducted in an inpatient facility, no such move is necessary; respondents found to meet the criteria simply remain in the same facility until the time of the hearing.)

The physician conducting the initial evaluation sends a written statement of his or her findings to the clerk of the court that ordered the evaluation. If the findings indicate that the respondent is to be detained, the clerk assigns legal counsel to the respondent, sets a date for the hearing, and notifies the respondent, the respondent's attorney, and the petitioner of the time and place of the hearing. (In Winston-Salem, as a matter of practice, a hearing date is set and notice of the hearing is provided to the petitioner at the time that the custody order is issued.)

If the petitioner is a qualified physician, the initial examination described above is not conducted; rather, the respondent is taken directly to an in-patient facility for evaluation and custody pending the hearing.

Within 24 hours of admission to the inpatient facility, the respondent is again examined by a qualified physician to determine whether he or she meets the commitment criteria. (In Winston-Salem, where the respondent remains in the facility in which the initial evaluation was conducted, a second evaluation usually is not conducted until about 2 to 4 days following admission.) If the examining physician finds that the respondent continues to meet the commitment criteria, the respondent is held at the facility pending the hearing. If the physician finds that the respondent does not meet the criteria, however, the respondent may be released pending the hearing. (Note that if the first examining physician finds the respondent not to meet the commitment criteria, the proceedings are terminated; if the second finds the respondent not to meet the criteria, a hearing is held regardless of whether the respondent is released.)

A hearing is held within 10 days from the time that the respondent is taken into custody. If the hearing is held in a regional psychiatric institution, an attorney general represents the state; the district attorney represents the state in hearings held in the district court in Winston-Salem. A judge hears testimony and determines whether there is 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. If the judge finds that the respondent does not meet the criteria, the case is dismissed. If the judge finds that the respondent does meet the criteria, however, he or she may order inpatient or outpatient treatment at a mental health facility for a period of up to 90 days. Other than release, outpatient treatment is the only dispositional option available to the judge that is less restrictive than involuntary hospitalization. A judge may order outpatient treatment only after making findings of fact regarding the availability of appropriate community care and treatment.

The respondent may appeal the judge's commitment order to the Court of Appeals. The order, however, remains in full effect during the appeal unless the Court of Appeals orders otherwise. Appeals are very rarely pursued in Winston-Salem.

During the commitment period, the chief of medical services of the treating institution may discharge the respondent unconditionally at any time that he or she determines that the respondent no longer is in need of hospitalization. He or she also may release the respondent conditionally for periods up to 30 days, on specified conditions. Violation of the conditions is grounds for return of the respondent to the releasing facility.

If the chief of medical services determines that the respondent needs treatment beyond the initial commitment period, he or she may so notify the clerk of court at least 15 days before the end of the period. Upon receipt of such notice, the clerk schedules a hearing to be held before the end of the initial treatment period and notifies the respondent and the respondent's attorney of the time and place of the hearing. At this hearing, the judge may order continued treatment for a period not to exceed 180 days. At the end of this treatment period, and at the end of all subsequent treatment periods, hearings may be held to continue court-ordered treatment for periods up to one year each.

If the respondent is committed to a community mental health facility, assigned counsel remains responsible for his or her representation until counsel is discharged by order of the court or until the respondent is unconditionally discharged from the facility. If the respondent is committed to one of the state's regional psychiatric institutions, "special counsel" appointed by the senior resident superior court judge of the judicial district in which the facility is located is responsible for such representation.

At any time during his or her commitment, a respondent may request to become a voluntary patient. In accordance with the voluntary admission agreement, voluntary patients who request to be discharged may be retained by a facility for up to 72 hours. If hospital staff believe that a voluntary patient who is seeking discharge meets the involuntary commitment criteria, they may petition (or arrange to have a member of the patient's family petition) to have the patient committed involuntarily.

Before an involuntary patient is discharged, the facility ordinarily attempts to arrange an appropriate placement for the patient in the community. If mental health problems arise again, which unfortunately is the case for many former patients, the entire process is begun anew.

The initiation stage of the involuntary commitment process may be different in emergency cases. If someone meets the commitment criteria and is "also violent and requires restraint, and delay in taking him to a qualified physician for examination would likely endanger life or property" (hereinafter, "emergency circumstances"), a law enforcement officer may take the person into custody and deliver him or her directly to a magistrate or clerk. The law enforcement officer executes an affidavit and swears to the emergency circumstances. If the magistrate or clerk finds by "clear, cogent, and convincing" evidence that the facts in the officer's affidavit are true and that the emergency circumstances do, in fact, exist, he or she issues an order for the person to be taken directly to a community or regional mental health facility for custody and observation pending a hearing. The initial, "screening" examination is not required in such emergency cases. (As a matter of practice in Winston-Salem, law enforcement officers frequently take emergency cases directly to a treatment facility and arrange for another officer or staff of the facility to detain the respondent while the custody-taking officer appears before the magistrate or clerk.)

# CHAPTER V. SUMMARY OF RECOMMENDATIONS

This report is intended to be of practical use to the courts and agencies in Winston-Salem that provide services to the mentally ill. In addition to describing Winston-Salem's civil commitment system, the report presents practical recommendations for improvement in the system. The recommendations were derived from several sources. Many were taken from suggestions made by people working in the Winston-Salem system. Others are variations of suggestions made by professionals in the other project sites to accomodate their systems' problems. Some recommendations spring primarily from the research staff's observations of civil commitment practices in Winston-Salem and from the staff's review of the professional literature on this topic.

Each of the major chapters of this report contains a number of recommendations. After studying this report, or simply from being familiar with commitment procedures in Winston-Salem, the reader may be surprised that some recommendations have not been made. Many issues in Winston-Salem can be identified on which recommendations might have been offered but were not. The absence of recommendations addressing particular issues can be accounted for in two ways. First, if the Winston-Salem system is administering a certain procedure in a manner that appears impossible to improve upon, no recommendation is made. Thus, to some extent, the lack of a recommendation may be taken as implicit approval of the status quo. Second, situations are identified in the report in which the countervailing factors are so nearly weighted that any recommendation would be hard to justify. In these situations, the preference was to make no recommendation rather than to present a recommendation with a weak foundation. It should be apparent after reading the report why partiuclar recommendations were not made, as well as why others were.

Recommendations are made throughout the report as they arise from the textual discussions. The text is organized in an approximately chronological fashion, as events ordinarily unfold during a commitment proceeding. In this chapter, the recommendations are reproduced according to the chapter in which they appear in the text. Thus, when reading any recommendation in this chapter, one can quickly turn to the chapter from which the recommendation was taken and locate the textual discussion accompanying the recommendation. In this chapter, the recommendations are presented in summary form only, without discussion. The full report must be reviewed for a complete understanding of the way in which each recommendation relates to other elements of the system.

## RECOMMENDATIONS

### A. RELATING TO THE PREHEARING PROCESS

RECOMMENDATION: IN ORDER TO IMPROVE ACCESS OF PROSPECTIVE PETITIONERS AND THE POLICE TO THE MAGISTRATES, IT IS RECOMMENDED THAT ONE OR MORE OF THE FOLLOWING PROCEDURES 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.

RECOMMENDATION: A STATUTORY AMENDMENT SHOULD BE SOUGHT AUTHORIZING A LAW ENFORCEMENT OFFICER TO TRANSPORT A RESPONDENT DIRECTLY TO A MENTAL HEALTH FACILITY IN AN EMERGENCY SITUATION.

RECOMMENDATION: THE CLERK AND THE MAGISTRATES SHOULD VERY CAREFULLY REVIEW THE ALLEGATIONS OF PETITIONERS BEFORE APPROVING PETITIONS AND ISSUING CUSTODY ORDERS.

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 OF ARRIVING AND ALERT FACILITY PERSONNEL 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, 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 IS POSSIBLE. IF THE CUSTODY-TAKING IS DELAYED, THE OFFICER IMMEDIATELY SHOULD TELEPHONE THE FACILITY AND REPORT THE DELAY.

RECOMMENDATION: THE OFFICER TAKING THE RESPONDENT TO THE MENTAL HEALTH FACILITY FOR EVALUATION SHOULD REMAIN AT THE FACILITY, IF POSSIBLE, UNTIL THE PHYSICIAN HAS COMPLETED HIS OR HER EVALUATION AND MADE A COMMITTABILITY DETERMINATION; EXCEPT THAT IF IT REASONABLY IS FORESEEN THAT NO PHYSICIAN WILL BE AVAILABLE TO BEGIN THE EVALUATION WITHIN 30

MINUTES OF THE OFFICER'S ARRIVAL AT THE FACILITY, THE OFFICER MAY LEAVE THE RESPONDENT IN THE CUSTODY OF THE FACILITY. IN ANY EVENT, AS IS RECOMMENDED IN THE PREHEARING DISCHARGE SECTION, BELOW, 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.

RECOMMENDATION: THE CLERK SHOULD INDICATE CLEARLY ON THE "INSTRUCTIONS FOR SERVICE OF INVOLUNTARY COMMITMENT PAPERS" THAT IF THE FACILITY TO WHICH THE LAW ENFORCEMENT OFFICER IS INSTRUCTED TO DELIVER THE RESPONDENT REFUSES TO RECEIVE THE RESPONDENT FOR EVAUATION, THE OFFICER MAY DELIVER THE RESPONDENT TO ANOTHER APPROVED FACILITY FOR EVALUATION.

RECOMMENDATION: IF IT IS NOT POSSIBLE TO COMPLY WITH STATUTORY PROVISIONS IN ALL RESPECTS WITHIN THE ARRANGEMENT OF CONDUCTING HEARINGS ONE DAY PER WEEK, HEARINGS SHOULD BE CALENDERED ON OTHER DAYS AS NECESSARY TO ENSURE COMPLIANCE.

RECOMMENDATION: IT SHOULD BE THE RESPONSIBILITY OF STAFF OF THE FACILITY IN WHICH RESPONDENT IS TO BE DETAINED PENDING A COMMITMENT HEARING TO INFORM RESPONDENT OF HIS OR HER RIGHT TO HAVE FAMILY MEMBERS OR OTHERS NOTIFIED OF THE DETENTION. STAFF SHOULD EXPLAIN TO RESPONDENT THAT, UNLESS HE OR SHE OBJECTS, THE NEXT OF KIN WILL BE NOTIFIED OF THE DETENTION. IF 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.

RECOMMENDATION: REGARDLESS OF HOW MANY EXAMINATIONS ARE REQUIRED, 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.

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.

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 BY THE QUALIFIED PHYSICIAN DESCRIBED IN SECTION 122-58.6. (NO INDEPENDENT EXAMINATION NEED BE PROVIDED AS A CHECK ON THE INITIAL, "SCREENING" EVALUATION CONDUCTED PURSUANT TO SECTION 122-58.4).

RECOMMENDATION: PENDING A COMMITMENT HEARING, 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 RESPONDENT DURING THE PREHEARING DETENTION PERIOD AND RESPONDENT'S TREATING PHYSICIAN HAS ANY REASON TO BELIEVE THAT 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 COMMITMENT JUDGES INDICATING THE BEHAVIORAL EFFECTS OF PARTICULAR MEDICATIONS FREQUENTLY USED TO TREAT PSYCHIATRIC PATIENTS.

RECOMMENDATION: BEFORE THE RESPONDENT IS TREATED WITH MEDICATION, THE TREATING PHYSICIAN SHOULD MEET WITH THE RESPONDENT AND INQUIRE WHETHER THE RESPONDENT HAS BEEN TREATED WITH ANTI-PSYCHOTIC OR OTHER PSYCHOTROPIC MEDICATIONS IN THE PAST AND WHETHER, AS A RESULT OF THIS, RESPONDENT HAS A PREFERRED MEDICATION OR TREATMENT.

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. BEFORE MAKING A FINDING THAT THE RESPONDENT DOES NOT MEET THE COMMITMENT CRITERIA, THE PHYSICIAN CONDUCTING THE SECOND EVALUATION OF THE RESPONDENT SHOULD BE PERMITTED TO CONSULT THE PHYSICIAN WHO CONDUCTED THE INITIAL EVALUATION AND DETERMINE WHETHER THERE ARE FACTS OR OTHER EVIDENCE THAT WOULD RENDER A FINDING OF NONCOMMITTABILITY INAPPROPRIATE.

B. RELATING TO COUNSEL FOR RESPONDENT

RECOMMENDATION: THE COURTS AND THEIR ALLIED AGENCIES IN WINSTON-SALEM SHOULD STUDY THE POSSIBILITY OF CREATING A NEW SYSTEM FOR PROVIDING COUNSEL TO INDIGENTS IN INVOLUNTARY COMMITMENT CASES. OTHER SYSTEMS THAT SHOULD BE INVESTIGATED INCLUDE THE TYPE USED IN NEW YORK (THE MENTAL HEALTH INFORMATION SERVICE, AN ADVOCACY ORGANIZATION RESPONSIBLE

PRIMARILY FOR REPRESENTING THE INTERESTS OF PATIENTS IN PSYCHIATRIAC HOSPITALS), THE PUBLIC DEFENDER SYSTEM (USED, FOR EXAMPLE, IN CHICAGO, ILLINOIS), AND THE SPECIAL COUNSEL SYSTEM USED IN THE REGIONAL FACILITIES IN NORTH CAROLINA.

RECOMMENDATION: ASSIGNMENT OF COUNSEL ALWAYS SHOULD BE MADE AT LEAST 48 HOURS BEFORE THE TIME SCHEDULED FOR HEARING.

RECOMMENDATION: THE COURT SHOULD SPONSOR PERIODIC SEMINARS ON THE INVOLUNTARY CIVIL COMMITMENT PROCESS IN WINSTON-SALEM AND THE ROLE OF RESPONDENT'S COUNSEL IN THIS PROCESS. NO ATTORNEY SHOULD BE ELIGIBLE TO RECEIVE APPOINTMENTS OF COMMITMENT CASES UNTIL HE OR SHE HAS EITHER ATTENDED SUCH A SEMINAR OR VIEWED A FILM OR VIDEO TAPE OF SUCH A SEMINAR.

RECOMMENDATION: THE ROLE OF RESPONDENT'S COUNSEL SHOULD BE DISCUSSED AND EXPLORED BY THE WINSTON-SALEM LEGAL AND MENTAL HEALTH COMMUNITIES. SERIOUS ATTENTION SHOULD BE GIVEN TO THE NATIONAL TRENDS AND REASONS FOR HAVING COUNSEL ASSUME A STRONG ADVOCACY ORIENTATION.

RECOMMENDATION: COUNSEL FOR RESPONDENT SHOULD BE REQUIRED TO MEET WITH RESPONDENT AND DISCUSS 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 TO REPRESENT RESPONDENT. 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.

RECOMMENDATION: RESPONDENT'S ATTORNEY SHOULD BE PROVIDED ACCESS TO RESPONDENT'S HOSPITAL RECORDS REGARDLESS OF WHETHER RESPONDENT HAS PROVIDED EXPRESSED PERMISSION.

RECOMMENDATION: AT THE TIME THAT THE EXAMINING PHYSICIAN SENDS HIS OR HER REPORT TO THE COURT, HE OR SHE ALSO SHOULD SEND A COPY OF THE REPORT TO RESPONDENT'S ATTORNEY.

RECOMMENDATION: RESPONDENT'S COUNSEL SHOULD MAKE AN EFFORT TO NOTIFY IN ADVANCE PERSONNEL OF A FACILITY WHEN HE OR SHE WISHES TO SPEAK WITH A PHYSICIAN AT THE FACILITY; UPON RECEIVING SUCH NOTIFICATION, THE FACILITY PERSONNEL SHOULD ATTEMPT TO ARRANGE FOR THE PHYSICIAN TO BE AVAILABLE TO MEET WITH RESPONDENT'S COUNSEL.

RECOMMENDATION: THE JUDGES OF THE DISTRICT COURT SHOULD DISCUSS AND EXPLORE THE POSSIBILITY OF ESTABLISHING GUIDELINES FOR ORDERING HIGHER-THAN-USUAL FEES TO COUNSEL FOR RESPONDENTS IN INVOLUNTARY COMMITMENT PROCEEDINGS AND SHOULD NOTIFY THE LOCAL BAR OF ANY GUIDELINES ESTABLISHED.

C. RELATING TO THE HEARING

RECOMMENDATION: RESPONDENT'S ATTENDANCE AT HIS OR HER HEARING SHOULD BE MANDATORY UNLESS RESPONDENT'S ATTENDING PHYSICIAN STATES IN WRITING THAT RESPONDENT'S APPEARANCE IN COURT WOULD SUBSTANTIALLY IMPAIR RESPONDENT'S MENTAL OR EMOTIONAL STABILITY OR WOULD SERIOUSLY THREATEN THE SAFETY OF OTHERS.

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 USED TO ENABLE EXAMINING PHYSICIANS TO PRESENT THEIR TESTIMONY AND SUBMIT TO CROSS EXAMINATION BY TELEPHONE. SUCH A SYSTEM SHOULD INCLUDE RECEPTION, TRANSMISSION, AND AMPLIFICATION EQUIPMENT CAPABLE OF ALLOWING ALL OF THE PARTICIPANTS IN THE HEARING TO HEAR THE TESTIMONY OF THE EXAMINING PHYSICIAN AND DIRECT QUESTIONS TO HIM OR HER. SHOULD THE COURT DECIDE NOT TO USE SUCH A SYSTEM, IT SHOULD REFUSE TO ALLOW RESPONDENT'S COUNSEL TO STIPULATE TO THE REPORT OF THE EXAMINING PHYSICIAN ABSENT A REPRESENTATION BY RESPONDENT'S COUNSEL THAT HE OR SHE DISCUSSED THE POSSIBLE CONSEQUENCES OF THE STIPULATION WITH RESPONDENT AND RESPONDENT ACQUISCED IN THE STIPULATION.

RECOMMENDATION: ALL REPORTS SUBMITTED TO THE COURT BY EXAMINING PHYSICIANS SHOULD BE TYPED.

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 RESPONDENT.

RECOMMENDATION: MEASURES SHOULD BE TAKEN TO ENSURE THAT THE PUBLIC CAN NEITHER VIEW NOR LISTEN TO COMMITMENT HEARINGS.

RECOMMENDATION: THE COURT SHOULD INVESTIGATE THE FEASIBILITY OF SEQUESTERING RESPONDENTS FROM THE COURTROOM DURING HEARINGS IN WHICH THEY ARE NOT INVOLVED.

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 TESTIMONY THAT IS HIGHLY OBJECTIONABLE IS GIVEN OVER NO OBJECTION, THE COURT SHOULD ALERT COUNSEL THAT RULES OF EVIDENCE SHOULD BE BETTER FOLLOWED.

RECOMMENDATION: BEFORE ORDERING INVOLUNTARY TREATMENT, THE COURT SHOULD CONSIDER WHETHER ANY LESS RESTRICTIVE ALTERNATIVE WOULD BE APPROPRIATE TO ACCOMODATE 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 THAT IT WAS FOUND NOT TO BE APPROPRIATE.

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 COMMITMENT FOR RESPONDENTS IN COMMITMENT PROCEEDINGS. IT SHOULD BE THE RESPONSIBILITY OF 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.

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-COMPLAINT, 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.

D. RELATING TO POSTHEARING CONCERNS

RECOMMENDATION: IT SHOULD BE THE RESPONSIBILITY OF STAFF OF THE FACILITY IN WHICH RESPONDENT IS COMMITTED TO INFORM RESPONDENT OF HIS OR HER RIGHT TO HAVE FAMILY MEMBERS AND OTHERS (WITHIN REASON) NOTIFIED OF THE COMMITMENT AND OF ANY SUBSEQUENT DISCHARGE. STAFF SHOULD EXPLAIN TO RESPONDENT THAT UNLESS HE OR SHE OBJECTS, THE NEXT OF KIN OR GUARDIAN WILL RECEIVE SUCH NOTIFICATION. IF 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.

RECOMMENDATION: IMMEDIATELY FOLLOWING AN ORDER OF COMMITMENT, RESPONDENT'S COUNSEL SHOULD EXPLAIN TO RESPONDENT HIS OR HER RIGHT TO APPEAL AND SHOULD BE AVAILABLE TO PURSUE AN APPEAL FOR RESPONDENT IF 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 RESPONDENT'S BEHALF AND SHOULD NOTIFY THE LOCAL BAR OF THIS POLICY. THE COURT OF APPEALS SHOULD MAINTAIN AN EXPEDITED CALENDAR FOR COMMITMENT APPEALS, WHICH WOULD ALLOW SUCH APPEALS TO BE HEARD WITHIN FIFTEEN DAYS OF FILING.

RECOMMENDATION: A COPY OF THE PETITION FOR TRANSFER SHOULD BE SERVED ON THE PATIENT AND THE PATIENT'S COUNSEL AT LEAST 48 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 48-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 AND SHOULD NOTIFY THE LOCAL BAR OF THIS POLICY.

RECOMMENDATION: PERSONS RESPONSIBLE FOR DISCHARGE PLANNING AT THE FACILITIES IN WINSTON-SALEM SHOULD MORE FREQUENTLY CONSIDER CONDITIONAL RELEASE AS A DISCHARGE OPTION.

RECOMMENDATION: UNLESS A SYSTEM IS DEVELOPED IN WINSTON-SALEM WHEREBY A SPECIAL COUNSEL IS DESIGNATED TO BE RESPONSIBLE FOR REPRESENTING RESPONDENT'S INTERESTS DURING THE PERIOD OF COMMITMENT, COUNSEL ASSIGNED TO REPRESENT RESPONDENT AT THE INITIAL HEARING SHOULD BE REQUIRED TO REMAIN RESPONSIBLE FOR RESPONDENT'S REPRESENTATION DURING THE COMMITMENT PERIOD (AS REQUIRED BY LAW). IN ORDER FOR SUCH POST-COMMITMENT REPRESENTATION TO BE EFFECTIVE, COUNSEL SHOULD BE REQUIRED TO HAVE CONTACT BY MAIL, BY TELEPHONE, OR IN PERSON, WITH RESPONDENT OR OTHERWISE BE AVAILABLE AT THE FACILITY IN WHICH RESPONDENT IS DETAINED AT LEAST MONTHLY DURING THE PERIOD OF COMMITMENT.

# CHAPTER VI. THE PREHEARING PROCESS

This chapter considers the events in an involuntary commitment proceeding that occur prior to a formal hearing. Many cases are disposed of in the prehearing stage. Respondents may be screened out by the clerk who reviews the petitioner's allegations or by the physician who conducts the initial evaluation; or they may be admitted to a treatment facility for prehearing custody and observation but be discharged before a hearing is held. Some respondents become voluntary patients.

What happens with cases 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 a prompt but thorough evaluation procedure and a diversion of inappropriate cases at an early stage protect both the liberty interests of the respondent and the pocketbook of the taxpayer.

Discussed below are the procedures in Winston-Salem for initiating the commitment, picking up the respondent, screening the respondent, detaining the respondent pending the hearing, examining the respondent, treating the respondent before the hearing, and discharging the respondent before the hearing.

## Description

### A. INITIATING THE COMMITMENT

The North Carolina statutes provide that anyone who has knowledge 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, may appear before a clerk (or assistant or deputy clerk) of the superior court or a magistrate of the district court and execute an affidavit to this effect and petition the clerk or magistrate for issuance of an order to take the respondent into custody for examination by a qualified physician. N.C. Gen. Stats. §122-58.3(a)(1981). 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. §122-58.3(d). If the clerk or magistrate finds reasonable grounds to believe that the facts alleged in an affidavit are true and that the respondent probably meets the criteria for commitment, he or she must issue an order to a law enforcement officer to take the respondent into custody for examination by a qualified physician. §122-58.3(b).

The North Carolina statutes provide that under particular emergency circumstances (when a person subject to commitment 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"), a law enforcement officer may take the person into custody and take him or her immediately before a magistrate or clerk. In this situation, the law enforcement officer executes the affidavit and swears 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 the emergency circumstances exist, he or she must order the law enforcement officer to take the respondent directly to a community or regional mental health facility for inpatient custody and observation pending a court hearing. §122-58.18.

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 their residences during the evening hours and on weekends. Throughout this report, unless otherwise noted, references to the clerk are intended as applying to the magistrates as well.

Petitioners frequently are referred to the court by the police or by staff of the local mental health facilities. A petitioner may initiate a proceeding by telephoning the clerk and explaining briefly what events have transpired that make him or her want a person committed. If the situation clearly does not warrant court intervention, the clerk will refer the caller to other assistance. (Cases involving alcohol or drug abuse routinely are diverted.) If the allegations may provide reasonable grounds to believe that someone 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 arrives, the clerk explains the commitment procedure and asks the petitioner to describe in detail the circumstances that motivated him or her to seek to have someone committed. The clerk reviews the facts alleged, and, if the facts are insufficient, he or she may suggest that the petitioner seek help for the person in some way other than by involuntary commitment. If the facts are sufficient, the clerk types out a petition and has the petitioner sign and give an oath. Then the clerk issues a custody order to be served on the respondent, schedules a hearing, and issues notices of the hearing to be served on the respondent and the petitioner. In addition, the clerk completes a form entitled "instructions for service of involuntary commitment papers," which indicates what the law enforcement officer should expect when picking up the respondent, where the respondent should be taken for examination, and what the officer should do after the respondent is delivered for examination. The clerk also signs an order authorizing the law enforcement officer to transport the respondent to a mental health facility. Copies of the forms used by the clerk are contained in Appendix A.

Before indicating on the instructions where the respondent is to be taken, the clerk asks the petitioner whether he or she would prefer commitment to a private facility. If petitioner would prefer this and is

able to afford it (or represents that respondent can afford it), the clerk allows the petitioner sufficient time to contact one of the city's private facilities and make arrangements for respondent's admission. If arrangements can be made, the clerk notes on the papers for the law enforcement officer that the respondent is to be taken to the private facility. Otherwise, the clerk indicates that the respondent is to be taken to a public facility (usually the Forsyth-Stokes Community Mental Health Center. Regardless of whether respondent is to be taken to a private or public facility, the clerk attempts to arrange with the petitioner to have a member of the respondent's family present when the police take the respondent into custody.

After preparing the petition, the custody order, and the other necessary papers, the clerk telephones the police, who usually arrive within thirty minutes. The respondent is typically taken into custody within two hours of the time that the petition is completed. (As indicated later in this report, these time periods may be substantially longer if magistrates are involved.)

In emergency cases in Winston-Salem, law enforcement officers typically take the respondent directly to a mental health facility and arrange for him or her to be detained there either by another officer or by the facility staff while they go to the clerk to petition for the commitment and arrange for the necessary papers.

By all reports, the assistant clerk of the superior court usually is readily available to petitioners and the police during regular working hours. A number of people in Winston-Salem complained that the district court magistrates were not so available, however. Reportedly none of the magistrates lives in Winston-Salem--they all live "out in the country," which necessitates a drive of 20 to 30 minutes each way for petitioners and the police. Moreover, the magistrates reportedly do not always cooperate with petitioners or police--if a case arises shortly before the end of a magistrate's shift, the magistrate may suggest that petitioners and police wait and take the case to the assistant clerk of the court during regular hours. People in Winston-Salem report that the assistant clerk of the court usually provides very good service and carefully reviews the facts before issuing a petition; however, the magistrates are said to vary considerably in the quality of review they give.

### B. PICKING UP THE RESPONDENT

The North Carolina statutes provide that, within 24 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 48 hours, the officer must take the respondent to a community mental health center for examination by a qualified physician. If a qualified physician is not available in the community mental health center, the officer must take the repondent to any qualified physician who is available locally. If no physician is immediately available, the

officer may temporarily detain the respondent in a community mental health facility, if one is available, or if none is available, may arrange for detention of the respondent, under appropriate supervision, in the respondent's home, in a private hospital or a clinic, in a general hospital, or in a regional mental health facility, but not in a jail or other penal facility. §122-58.4(a). If the affiant who obtained the custody order is a qualified physician (in which case no initial, "screening" examination is required), the law enforcement officer is to take the respondent directly to a mental health facility for custody and observation pending a hearing. §122-58.4(b).

As indicated earlier, in an emergency situation (respondent is violent and requires restraint and delay in transporting respondent endangers life or property), a law enforcement officer may take the respondent into custody without prior judicial approval and take him or her immediately before a magistrate or a clerk. If the magistrate or a clerk finds by clear, cogent, and convincing evidence that the person meets the criteria for emergency commitment, he or she may order the law enforcement officer to take the respondent directly to a community or regional mental health facility for custody and observation pending a hearing. §122-58.18. The manner in which police in Winston-Salem handle emergency cases is described in the preceding section, INITIATING THE COMMITMENT.

If 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 county director of social services of the county of the female's residence, or the county of admission. §122-49. The statutes authorize the officer issuing the custody order under certain circumstances to permit family or immediate friends of the respondent, if they request, to transport the respondent. §122-58.14(d). We were told, however, that, in practice, this rarely is done.

The statutes provide that, whenever feasible, law enforcement officers transporting respondents should dress in plain clothes and should use unmarked vehicles. §122-58.14(b). 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." §122-58.14(c).

During business hours, a special, three-officer, plain-clothes unit of the Winston-Salem police department is responsible for the transportation of respondents in the City of Winston-Salem. (The unit also is responsible for juvenile investigations.) 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. Respondents from counties served by the Winston-Salem courts are transported by law enforcement officers from the counties' sheriff's departments.

In cases originating with a petition (non-emergency cases), after preparing the petition and custody order, the clerk or magistrate calls the plain-clothes unit, and an officer from that unit reports to the clerk or magistrate, picks up the papers, and goes to the place indicated to pick up the respondent. Reportedly, most of the time (about 70%), the officer has no difficulty locating the respondent or taking him or her into custody. At other times, the custody-taking is aggravated by resistance from the respondent. If the officer anticipates such resistance or if the respondent becomes resistant during the custody-taking, the officer may call for a uniformed officer to assist in taking the respondent into custody. Occasionally, an ambulance is needed for transporting the respondent.

What happens after the respondent and the police have arrived at a mental health facility depends on which facility they are at. At the public facility, Forsyth-Stokes Community Mental Health Center, the officer must wait with the patient until the examining physician arrives and conducts the examination. It was reported that during business hours an officer usually must wait approximately 30 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 60 minutes.

At the private hospitals (Forsyth Memorial and the Mandala Center), the officers are permitted to leave the hospital and the hospital will maintain the respondent in custody until the physician arrives to conduct the mental health examination. It was suggested that the private facilities agree to do this because respondents bound for private hospitals generally are not as aggressive or difficult to hold and because it may take significantly longer, particularly during off-hours, for physicians to become available to conduct examinations at private hospitals.

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

After the examination, if the physician decides to release the respondent, the officer returns the respondent to his or her home or to the place where he or she was picked up. Although the custody order ordinarily permits the officer to deliver the respondent to "any approved treatment facility," the "instructions for service of involuntary commitment papers" are specific with regard to delivery of respondent, designating a single receiving facility. Police officers in Winston-Salem believe that they have no option to take the respondent to an alternative facility without receiving new instructions to do so.

Therefore, if a facility refuses to receive a respondent ordered for evaluation (which reportedly has happened on rare occasions in the past), police officers feel compelled to release the respondent. Representatives of the court, however, maintain that officers are not constrained by the clerk's instructions and may deliver respondents refused at one facility to another approved facility for examination. (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.)

In Winston-Salem, the facility to which the respondent is taken initially usually is the one in which he or she will be detained pending the hearing. This variation from the statutory provision concerning 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 Winston-Salem city police make no particular effort to have a family member or designated female accompany an officer engaged in the transportation of a female respondent; however, we were told that they have a procedure of recording time and odometer readings when a female respondent is placed in a police car and, again, when the police car arrives at its destination. The purpose of this procedure is to discourage police misconduct and create records to protect the police department against any charges of improper conduct during the period of transportation. It was reported that the sheriff's departments in the counties served by the courts in Winston-Salem generally comply with the law requiring female respondents to be accompanied by members of their families or by a female designated by the county. However, no one with whom we spoke in Winston-Salem was familiar with the workings of this procedure.

C. SCREENING THE RESPONDENT (The Initial Examination)

The law provides that the qualified physician must examine the respondent as soon as possible, and in any event within 24 hours after the respondent is presented for examination at the facility. §122-58.4(c). (As noted earlier, the initial evaluation is not required if the affiant was a qualified physician or if respondent was taken into custody pursuant to the emergency procedure.) If the physician finds that the respondent meets the statutory criteria for detention, the law enforcement officer is required to take the respondent to a community or regional mental health facility or public or private facility for temporary custody, observation, and treatment pending the hearing. If the physician finds that the respondent does not meet the criteria, the respondent is released and the proceedings are terminated. The findings of the qualified 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 48 hours of the time that it was signed, the physician also must communicate his findings to the clerk by telephone. §122-58.4.

The statute contemplates that this initial examination will function essentially as an outpatient, community screening of the respondent to determine whether it is appropriate for a commitment proceeding to continue. In Winston-Salem, because this initial examination is conducted at the facility in which the respondent may be detained prior to hearing, the results of the examination may be used to determine appropriate treatment as well as whether the proceeding should continue. At this initial evaluation, the physicians typically do not explain to the respondent how the results of their examinations will be used. Although it varies from facility to facility, most initial examinations reportedly take from 3 to 20 minutes to complete. Physical examinations generally are not conducted at this time. The physician typically will read the petition, briefly examine the respondent, and ask a question or two of the police officer if he or she is present during the examination.

After the examination, the physician completes a State form (contained in Appendix A) indicating his or her findings regarding the respondent's condition. The completed form is given to the police officer, who returns it to the court. If the police officer is not available, the physician mails it to the court.

D. PREHEARING DETENTION

As was indicated earlier, the law provides that if a qualified physician during the initial evaluation of respondent determines that respondent is committable, respondent is to be transported to a community mental health facility or public or private facility for temporary custody, observation, and treatment pending a court hearing. If no community mental health facility is available, and if the respondent is indigent and unable to pay for his or her care at a private facility, the law enforcement officer is to take the respondent to a regional psychiatric facility. §122-58.4(c).

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, the respondent ordinarily need not be moved following the initial evaluation. Respondents awaiting hearings in Winston-Salem usually are detained in one of three local facilities: Forsyth-Stokes Community Mental Health Center ( a public community mental health center), Forsythe Memorial Hospital (a private facility), or Mandala Center (also a private facility). If the respondent is particularly violent, he or she may be detained prior to hearing at the John Umstead Hospital in Butner (one of four regional psychiatric facilities in North Carolina). Respondents virtually never are transferred from one facility to another during the prehearing period unless a medical emergency requires transfer to a general services hospital.

Contemplating the situation in which the respondent would have been transported to the detaining facility following an initial evaluation elsewhere, the law provides that, within 24 hours of arrival

at the detaining facility, the respondent must be examined by a qualified physician. §122-58.6. This second examination is described later in this report, in the PREHEARING EXAMINATION section. The law provides that if the physician conducting this evaluation finds that the respondent does not meet the commitment criteria, he or she must release the respondent pending the court hearing and notify the clerk of the court from which the respondent was sent. §122-58.6. The hospitals report, however, that they frequently retain respondents until their hearings despite findings of noncommittability at this evaluation.

The maximum time allowed by statute for prehearing detention is ten days (unless a continuance is ordered). §122-58.7(a). It was reported that hearings reliably are conducted within the statutory period in Winston-Salem. Hearings are held every Thursday. As a matter of practice, the clerk's office schedules respondents detained after midnight on Sunday for hearings the following week. Consequently, hearings are held from four to ten days after detention.

Although the law provides for notice to respondent and respondent's counsel of the time and place of the hearing, there is no requirement that notification of respondent's detention be given to anyone. The policies of the local facilities vary with regard to notice. Generally, petitioners are family members and, therefore, are already aware of the detention. Staff of one facility said that if respondent is brought in by a police officer, every effort is made to notify members of the respondent's family, although there is no formal policy to this effect. Staff at another facility reported that, although the hospital had no policy regarding notifications, families were nearly always involved in the treatment of the respondent. Policy at the third local facility generally is not to release information about patients without their consent.

## E. PREHEARING EXAMINATION

The law provides that a respondent must be examined by a qualified physician within 24 hours of his or her arrival at the mental health facility in which he or she is to be detained prehearing. §122-58.6(a). Although the statutes do not specify the elements of the examination, the findings of the physician and the facts on which they are based must be put in writing and must be transmitted to the clerk of the superior court by "reliable and expeditious means." §122-58.6(b). The statutes also provide that if the affiant for commitment was a physician, a second qualified physician (who is not treating the patient) must perform the examination at the detaining facility. §122-58.3.

Because respondents in Winston-Salem usually are retained in the same facility in which they were examined initially, the second examination, as a practical matter, is not always conducted within 24 hours of admission. The policies of the local facilities vary on this. At two of the facilities, staff were unclear whether the second

examination was to be conducted within 24 hours of the respondent's arrival at the facility or within 24 hours of the first evaluation. In any event, staff at both facilities indicated that this requirement usually was not met and that the second evaluation typically was not conducted until about 2 to 4 days after the respondent's admission to the facility. In addition, a third evaluation reportedly is conducted at both of these facilities to provide the court with current information at the time of the hearing. At the third facility, second examinations reportedly are conducted about 2 to 4 days after the initial examination; if there is significant difference of opinion between the first two examination reports, a third examination usually is conducted.

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

Requests for independent examinations reportedly are very rare. When such requests are made, the hospital will not object if the respondent can afford to pay for the examination. However, no right is provided by statute to an independent examination at the government's expense.

It was reported that the "centerpiece" of the evaluation was the mental status examination, which typically takes anywhere from 5 to 30 minutes. Examining physicians sometimes also consult nurses' notes about the day-to-day experiences of respondent during the period of hospitalization.

The different facilities in Winston-Salem have different polices regarding whether to release respondent if an examiner's findings show that respondent no longer meets the commitment criteria. Some facility personnel reported that they believed that it was the judge's role to order this release and that, therefore, they retain the respondent until the time of the hearing; others said that they ordinarily discharge the respondent pending the hearing. Recall that a finding of noncommittability at the initial evaluation results in a dismissal of the proceeding; a hearing still is to 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.

F. PREHEARING TREATMENT

The North Carolina statutes provide that, pending the court hearing, the qualified physician attending the respondent is authorized to administer to the respondent "reasonable and appropriate medication and treatment that is consistent with accepted medical standards." §122-58.6. The statutes guarantee patients a right to treatment

"including medical care and rehabilitation, regardless of age, degree of retardation, or mental illness." §122-55.5. Patients also have a right to be free from unnecessary or excessive medication with drugs, and the use of drugs as punishment or discipline is prohibited. 122-55.6. 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. §122-55.6.

At no facility in Winston-Salem is the respondent given notice of any right to refuse treatment. Whether and to what extent such a right is extended to patients in practice varies among the city's treatment facilities. Staff at the facilities reported that treatment generally is not administered until the facility receives a petition and custody order. Staff at one of the facilities indicated that, once these items were received, if a patient were dangerous, he or she would have no right to refuse treatment; but if a patient were not dangerous, a right to refuse was recognized. This spokesperson added that only an indication of potential dangerousness is necessary--it is not necessary that the patient have committed overt, dangerous acts. Another person associated with the same facility indicated that the hospital policy was to not treat patients who 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, it would be necessary to have the patient adjudicated incompetent before he or she could be treated against his or her will. At another facility, a spokesperson said that the policy was that physicians would listen to an involuntary patient's request not to be treated and consider what was in the patient's best interests. For example, a physician would consider whether forcing medication would so destroy the rapport between doctor and patient as to have more of a negative effect on the patient's recovery than the lack of drugs would have. This spokesperson indicated that the facility's policy with regard to <u>voluntary</u> patients was different--that voluntary patients who were grossly psychotic and whose families agreed that treatment ought to be provided would be treated but that voluntary patients who were not psychotic would not be treated against their will. A spokesperson for the third hospital indicated that the question of right to refuse treatment never really arises--that the right is asserted so infrequently that no facility policy has been formulated. The rare patient who refused treatment, this person said, would likely be transferred to another facility.

Most involuntary patients in Winston-Salem reportedly are treated with medication during the prehearing detention period, and respondents typically are under the influence of medication at this hearing. Some respondents reportedly are so under the influence as to be unable to walk a straight line without stumbling.

## G. CONVERSION TO VOLUNTARY STATUS AND RETENTION OF VOLUNTARY PATIENTS

The statutes in North Carolina declare that it is the policy of the state to encourage voluntary admissions to treatment facilities. §122-56.1. The statutes provide that 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 by presenting himself or herself to the facility for evaluation. §122-56.3. In addition, a written application for evaluation or admission, signed by the person seeking admission, is required. In the applicaton, the applicant acknowledges that he or she may be held by the treatment facility for a period of 72 hours subsequent to any written request for release that he or she may make. 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. §122-56.3.

People in Winston-Salem voiced different opinions as to the frequency with which involuntary patients convert to voluntary status. Everyone agrees that it is attempted at least occasionally by the savvy respondent in an effort to obtain release. A number of community representatives have the impression that the local facilities recognize an absolute <u>right</u> of involuntary patients to convert to voluntary status and that many patients were converting and thereby obtaining their speedy release. Judges in Winston-Salem, however, indicate quite clearly that respondents have no right to convert to voluntary status--that they only have the right to request this conversion and that the attending physician maintains the authority to decide whether an involuntary patient should be allowed to convert (subject to approval by the court if the patient is awaiting his or her initial hearing). One judge said that if a respondent were before him during a hearing and the doctor's recommendation were that the respondent be allowed to convert to voluntary, he would approve the conversion unless other facts before the court compelled an involuntary commitment.

A spokesperson for one of the facilities in Winston-Salem said that 50 percent of the cases sent to the facility resulted in recommendations to the court that respondent be permitted to remain at the facility on a voluntary basis. 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 request to convert. The physicians generally agree that patients are not informed of any option to convert to voluntary status. If a patient appears to be requesting a conversion to voluntary status solely for the purpose of obtaining a speedy discharge, some physicians, rather than simply allowing the conversion, will discuss with the patient the best way for the patient to progress to an early but appropriate discharge.

Various perceptions exist in Winston-Salem regarding what is done with a dangerous voluntary patient who is requesting discharge. Community representatives and attorneys believe that facilities typically

grant the discharge request. However, spokespersons for the facilities say that if a voluntary patient requesting release is seriously ill and "really dangerous," the facility physicians either arrange for a relative of the patient to petition for involuntary commitment or, if this is not possible, submit a petition themselves. A spokesperson for one of the facilities states 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 involuntay commitment action. A spokesperson for another hospital said that if a dangerous, voluntary patient were seeking release and no member of the respondent's family were available and able to serve as petitioner, the hospital would do so, but if a family member were available and able but just unwilling, the hospital would not serve as petitioner unless continued commitment were "acutely necessary." It was alleged by some that the private facilities are much more likely to convert voluntary patients to involuntary status because this enables them to keep patients longer and, thereby, reduce the number of empty beds.

## H. PREHEARING DISCHARGE

The North Carolina statutes provide that if, in the opinion of the qualified physician conducting the initial examination of the respondent, the respondent does not meet the commitment criteria, the law enforcement officer must release the respondent and the proceedings are to be terminated. §122-58.4. Further, if in the opinion of the qualified physician conducting the second examination (or first if pursuant to emergency procedure or upon medical affidavit), the respondent does not meet the commitment criteria, then 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. §122-58.6. A provision probably designed for committed patients, but which arguably is applicable at the prehearing stage as well, provides that "the chief of medical services of a private or public mental health facility shall discharge a committed respondent unconditionally at any time he determines that the patient is no longer in need of hospitalization." §122-58.13. Finally, as indicated earlier in this report, a respondent may be discharged after having converted to voluntary status and requested release.

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. However, if the physician conducting the second examination concludes that the respondent is not committable, he or she may or may not be discharged. Some people 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 said that the discharge decision was for the treating physician to make and that the physician conducting the initial evaluation usually was the treating physician. This spokesperson said that 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 second examining physician and release the respondent or might decide to wait a few days to see how the respondent progressed in the facility before discharging him or her. Frequently, in such cases, the physician who conducted the first examination will conduct another examination to determine whether the conflicting opinion (that the person does not meet the commitment criteria) is a result of an improvement in respondent's condition. Even if the treating physician determines that the respondent no longer meets the criteria, however, the respondent may be held in the facility pending the hearing. When this happens, the physician's report to the court usually recommends that the case be dismissed at the hearing. At another facility, a spokesperson indicated that regardless of whether the second examining physician finds that the respondent meets the commitment criteria, the respondent always is detained in the facility until the time of the hearing. Judges in Winston-Salem report that if the physician's report to the court indicates that the respondent does not meet the commitment criteria, the respondent almost always is released at the hearing and the proceedings against him or her are terminated.

The treatment facilities in Winston-Salem do not have specific policies for providing notification of the prehearing discharge of respondents. Several former petitioners complain that the facilities, in fact, do not provide such noficication.

## Strengths, Weaknesses, and Recommendations for Improvement

### A. INITIATING THE COMMITMENT

The requirement that any attempt to initiate a commitment be subject to a judicial screening (by a clerk or magistrate) is a strength of the commitment system. Although it might be argued that this procedure delays bringing the respondent to treatment, this delay usually is minimal, at least during regular hours in Winston-Salem; moreover, the screening provides a legal protection for respondent (lessens the chance of inappropriate detention) and may benefit society (by avoiding the cost of unnecessary detention, examination, etc.). However, to the extent that clerks or magistrates are not readily available to screen allegations, the delay concern becomes weightier.

Some people in Winston-Salem feel that the use of magistrates during off-hours is not effective. Requiring prospective petitioners or police to travel outside of the city to the homes of magistrates is viewed by some as a serious weakness in the system, because it makes initiating a commitment difficult and slow. It is especially problematic for police involved in emergency situations because the law requires them to take respondents directly before a clerk or magistrate prior to hospitalization.

RECOMMENDATION: IN ORDER TO IMPROVE ACCESS OF PROSPECTIVE PETITIONERS AND THE POLICE TO THE MAGISTRATES, IT IS RECOMMENDED THAT ONE OR MORE OF THE FOLLOWING PROCEDURES BE IMPLEMENTED:

- o ONLY MAGISTRATES LIVING WITHIN THE CITY LIMITS OF WINSTON-SALEM SHOULD BE AUTHORIZED TO RECEIVE COMMITMENT APPLICATIONS.

- o A CLERK OR A MAGISTRATE WHO IS AUTHORIZED TO RECEIVE COMMITMENT APPLICATIONS SHOULD BE AVAILABLE AT THE COURTHOUSE AT ALL TIMES.

- o A SYSTEM SHOULD BE DEVELOPED TO ENABLE PETITIONS FOR INVOLUNTARY COMMITMENTS TO BE SUBMITTED AND APPROVED BY TELEPHONE.

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 police to take persons into custody under emergency circumstances is a strength of the North Carolina commitment system. It promotes the safety of society and provides for the immediate treatment needs of the person. Further, to the extent that it restricts such immediate custody-taking to particular, emergency situations, it respects the legal interests of the respondent, as well. Because the initial, community examination is dispensed with in emergency cases, the requirement that the clerk or magistrate find by clear, cogent, and convincing evidence that a respondent meets the commitment criteria is a strong feature of this procedure. However, because these cases do not require an initial mental health screening, it would appear appropriate, in our opinion, to have a provision requiring the release of respondent and the dismissal of all proceedings upon a

finding by the qualified physician conducting the first evaluation of respondent at the detaining facility that respondent does not meet the commitment criteria. A recommendation to this effect is presented later in this report.

Although it appears to be in violation of the law, the practice in Winston-Salem of taking 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, extremely violent, and 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, pursuant to the emergency procedure, respondents be taken immediately before a magistrate or clerk appears to have been written 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 the prehearing detention facilities serving Winston-Salem are local, though, no such long-distance transportation is necessary.

RECOMMENDATION: A STATUTORY AMENDMENT SHOULD BE SOUGHT AUTHORIZING A LAW ENFORCEMENT OFFICER TO TRANSPORT A RESPONDENT DIRECTLY TO A MENTAL HEALTH FACILITY IN AN EMERGENCY SITUATION.

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 respondent was taken into custody (e.g., within 25 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., 2 1/2 hours), no properly executed custody order is received by the facility.

The practices of the clerk's office (and presumably the magistrate's also) seem effectively to complement the statutory provisions and make for a workable initiation procedure. The practice of the clerk to explain the civil commitment procedure to petitioners is praised by many people in Winston-Salem. The opportunity provided to 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 the allegations, instructing the officer how to serve the involuntary papers, etc., seem to be well-designed to capture and convey important information.

Despite the overall apparent high quality of the initiation system, a number of persons in Winston-Salem (in both the mental health and the legal communities) complain that petitions too often are approved for persons who clearly do not meet the commitment criteria. Some people believe that the magistrates almost never deny a petition request. One psychiatrist stated that, in his opinion, petitioners often exaggerate allegations in order to persuade the clerk to approve the petition; he

suggested that very few respondents sent for evaluation truly are dangerous to themselves or others. Other people in Winston-Salem point out that by the time someone decides to petition for the commitment of another, he or she is so emotionally involved in the matter as not to be expected to act dispassionately. Further, they note, the burden of proof applicable in the clerk's screening is relatively low, and, therefore, it should not be surprising that many questionable cases survive this review (particularly cases arising during the off-hours when magistrates are on call, since these are more likely to grow out of emergencies). In any event, to the extent that inappropriate cases are processed through the system, respondents suffer an unnecessary deprivation of liberty and society suffers an unnecessary expense. Although it can be argued that persons who would benefit from treatment but who do not meet the criteria for commitment might receive a dose of beneficial treatment as a result of this practice, most people in Winston-Salem believe that respondents not meeting the commitment criteria should be screened out as soon as possible.

RECOMMENDATION: THE CLERK AND THE MAGISTRATES SHOULD VERY CAREFULLY REVIEW THE ALLEGATIONS OF PETITIONERS BEFORE APPROVING PETITIONS AND ISSUING CUSTODY ORDERS.

B. PICKING UP THE RESPONDENT

The law in North Carolina and the practice in Winston-Salem relating to the transportation of respondents in civil commitment proceedings are generally praiseworthy. 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 use of unmarked cars and plain-clothes police protects the legal interests of the respondent, and, to the extent that being taken into custody by uniformed officers is psychologically traumatic, may protect the treatment interests of the respondent as well. In addition, the provision of this service appears to present no significant costs to society. The practice of calling in uniformed officers to assist in the transportation of highly resistent respondents seems effectively to accomodate the occasional situation in which, perhaps as a result of mental disorder, a respondent refuses to recognize the authority of a plain-clothes individual to take him or her into custody. (We were told in another city that respondents sometimes think plain-clothes police are the CIA or KGB; in such a situation, the traditional police look not only retards respondent's resistance but it reduces trauma as well.)

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 taking a female respondent into custody did not seem to be a matter of concern to anyone with whom we spoke in Winston-Salem. Moreover, the department's special procedure of recording the time of day and odometer reading when respondent is taken into custody and comparing this with the

time of respondent's delivery and the odometer reading at that point provides a measure of protection against possible mishandling of respondents during the period of transportation. Nevertheless, the city police should be sensitive to the fact that their operating policy apparently is not in compliance with statute, and, 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 telephone a facility to which they will be delivering a respondent for evaluation so that the facility might arrange for a qualified physician to be available upon respondent's arrival at the facility is an excellent method for expediting the evaluation process, particularly during the evening hours and on weekends, when physicians are on call. An expedited evaluation process protects the respondent's liberty interests and provides for his or her treatment needs as well. Furthermore, any procedure that speeds up the process represents a cost savings for society. The refusal of facilities to summon a physician until the respondent arrives at the facility negates the possible benefits of the advance call by the law enforcement officer. However, when the custody-taking is delayed and the respondent is not delivered to the facility until long after the telephone call, the facility's valuable resources stand to be wasted.

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 OF ARRIVING AND ALERT FACILITY PERSONNEL 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, 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 IS 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 custody-taking law enforcement officer waits at the facility until the qualified physician has examined the respondent, has strong and weak features. One strength is that the officer's presence during the examination makes it possible for the qualified physician to question the officer about the circumstances under which the respondent was taken into custody. Also, it enables the officer promptly to return the respondent to his or her home should the respondent be found not to meet the commitment criteria. A weakness, though, is that an officer often must be idle for an hour or more while waiting for a qualified physician to become available to conduct the evaluation. 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 SHOULD REMAIN AT THE FACILITY, IF POSSIBLE, UNTIL THE PHYSICIAN HAS COMPLETED HIS OR HER EVALUATION AND MADE A COMMITTABILITY DETERMINATION; EXCEPT THAT IF IT REASONABLY IS FORESEEN THAT NO PHYSICIAN WILL BE AVAILABLE TO BEGIN THE EVALUATION WITHIN 30 MINUTES OF THE OFFICER'S ARRIVAL AT THE FACILITY, THE OFFICER MAY LEAVE THE RESPONDENT IN THE CUSTODY OF THE FACILITY. IN ANY EVENT, AS IS RECOMMENDED IN THE PREHEARING DISCHARGE SECTION, BELOW, 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.

A number of people in Winston-Salem believe that if the facility to which the respondent initially is taken for evaluation has no empty beds or for some other reason is unwilling or unable to receive the respondent for evaluation, the police officer must release the respondent because the instructions provided by the clerk specify only one facility to which the respondent may be taken. 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 <u>any</u> local facility is available to conduct an evaluation. Representatives of the court agree and dismiss this problem as a misunderstanding on the part of the local law enforcement officers. They say that the facility named in the instructions simply is the facility to which the respondent should be delivered first and that the instructions are not 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 IF THE FACILITY TO WHICH THE LAW ENFORCEMENT OFFICER IS INSTRUCTED TO DELIVER THE RESPONDENT REFUSES TO RECEIVE THE RESPONDENT FOR EVAUATION, THE OFFICER MAY DELIVER THE RESPONDENT TO ANOTHER APPROVED FACILITY FOR EVALUATION.

C. SCREENING THE RESPONDENT (The Initial Examination)

The statutory provision for an initial evaluation at a community mental health facility is a strong feature of the commitment system in North Carolina. It is especially important for respondents located in rural areas, because it prevents 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, since the facilities in which respondents in Winston-Salem usually are detained prior to prehearing are located in the city. The time limitations imposed by statute on this examination are important, as they insure that the respondent will be seen quickly, thereby protecting his or her liberty interests and treatment needs as well as society's interest in swift justice. The exception to the requirement for an initial community evaluation in emergency cases is compensated for 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.

Some people in Winston-Salem complain bitterly that physicians at the local facilities often are not readily available to conduct evaluations when respondents arrive, even during regular hours. While we would be reluctant to make a recommendation to this effect, it would be helpful if the facilities scheduled their staff in such a way as to leave at least one qualified physician available to conduct evaluations at all hours during the working day.

One possible weakness in North Carolina's law and in the practice in Winston-Salem, a matter that is quite controverserial in Winston-Salem as well as in other cities, concerns the lack of notification given to the respondent regarding the way the information generated by the evaluation is to be used. This question is discussed later in this report, in the PREHEARING EXAMINATION section.

D. 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 regional psychiatric facilities only if no community mental health facility is available and private commitment is not feasibile. People in Winston-Salem agree that detention in any of the three Winston-Salem facilities is preferable, from a therapeutic standpoint, to detention in the regional facility at Butner.

A possible weakness of the prehearing detention law is that it does not allow for a respondent to be released to the community pending the commitment hearing (unless, or course, a qualified physician has determined that the respondent does not meet the commitment criteria). However, given that the commitment criteria in North Carolina require that the respondent allegedly be dangerous to self or others, it is at least arguable that prehearing release rarely would be appropriate. Moreover, our research in states whose laws permit prehearing release reveals that, in practice, respondents virtually never are released pending their hearings.

A number of people in Winston-Salem suggest that 10 days is too long for respondents to be detained without some judicial review. In some states, a preliminary, probable cause hearing is required within a certain number of hours (or days) of the detention, followed by a full hearing thereafter. Our research reveals that, more often than not, this arrangement is unsatisfactory. In some jurisdictions requiring probable cause hearings, the practice has developed to conduct the full hearing within the time limits required for the probable cause hearing, thus avoiding the requirement that two hearings be held. This practice allows counsel very little time to prepare a meaningful case. Further, the extremely 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 screening procedure, such as the review of allegations done by the clerk in Winston-Salem. Although it is important that respondents be detained no longer than is necessary prior to hearing, we will refrain from recommending that probable cause hearings be conducted in North Carolina. Furthermore, we are reluctant to recommend that hearings be required in any less time than 10 days, given the logistics of appointing counsel, allowing counsel time to prepare a case, and scheduling a court hearing. However, it should be noted that were it not for the generally excellent screening provided by the clerk's review of allegations and the initial mental health examination, we would feel compelled to recommend a quicker judicial review.

The question of whether the prehearing detention period always is long enough for counsel to prepare an adequate case is a more serious one. Given that counsel is not appointed until the clerk receives notice that the physician conducting the initial examination has found that the respondent meets the commitment criteria (§122-58.5), that the physician need not present his or her findings to the clerk until 48 hours after the examination (§122-58.4(d), and that the examination need not be conducted until 24 hours after the respondent is presented for examination (§122-58.4(a)), it is possible for counsel not to be appointed until three or more days following the respondent's detention. Given that the law requires that counsel be appointed at least 48 hours in advance of the hearing (§122-58.5), it is conceivable, at least with respect to respondents detained on Sundays, for all of the actors in the process to comply with the law, yet the case not be legally hearable on a Thursday (because counsel cannot be appointed 48 hours before the upcoming Thursday and the following Thursday is beyond the 10 day maximum detention period). It should be noted that representatives of the court report that, as a practical matter, this problem rarely arises, presumably because the local physicians examine respondents and report their findings promptly. However, because of its potentiality and because local attorneys report having been assigned to commitment cases the evening before scheduled hearings (for whatever reason), we address the problem in this report.

Various solutions might be proposed for this problem, including some that would require statutory amendment. For example, one solution would be to extend the maximum permissible prehearing period beyond 10 days. Another would be to relax the 48-hour rule for counsel's appointment. Another solution seems more direct, however, and would require no statutory change: to hold hearings on days other than Thursdays, as necessary. No attorney should have to request a continuance in order to have 48 hours to prepare a defense; the court, when appointing counsel, should calender the case at least 48 hours following the appointment, whether or not this permits a Thursday hearing.

RECOMMENDATION: IF IT IS NOT POSSIBLE TO COMPLY WITH STATUTORY PROVISIONS IN ALL RESPECTS WITHIN THE ARRANGEMENT OF CONDUCTING HEARINGS ONE DAY PER WEEK, HEARINGS SHOULD BE CALENDERED ON OTHER DAYS AS NECESSARY TO ENSURE COMPLIANCE.

An area in which the statute in North Carolina is weak and the practice in Winston-Salem is inconsistant has to do with giving notice of respondent's detention to family members and others. The statute does require that the evaluating physician notify the court clerk of his or her findings (and, in effect, of respondent's detention) and that the clerk, in turn, assign counsel and notify counsel and respondent of the time and date of the hearing. But there is no requirement that anyone else be notified of respondent's status or that the hospitals or court refrain from notifying particular individuals whom respondent indicates that he or she does not want notified. Although the question of notice might be considered moot, because in practice most petitioners are family members, a notifications 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 respondent's competence to make such a decision is questionable. However, most of those with whom we have spoken about this issue agree that respondent's wishes in this regard should be respected.

RECOMMENDATION: IT SHOULD BE THE RESPONSIBILITY OF STAFF OF THE FACILITY IN WHICH RESPONDENT IS TO BE DETAINED PENDING A COMMITMENT HEARING TO INFORM RESPONDENT OF HIS OR HER RIGHT TO HAVE FAMILY MEMBERS OR OTHERS NOTIFIED OF THE DETENTION. STAFF SHOULD EXPLAIN TO RESPONDENT THAT, UNLESS HE OR SHE OBJECTS, THE NEXT OF KIN WILL BE NOTIFIED OF THE DETENTION. IF 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.

### E. PREHEARING EXAMINATION

The time constraints imposed by law on prehearing examinations present a problem for persons in Winston-Salem. Most feel that the statute was designed for the state's rural localities, where the two required examinations are conducted in different facilities. In Winston-Salem, where both examinations are conducted in the same facility, it generally is felt to be unnecessary for two examinations to be conducted within 24 hours of respondent's arrival at the facility. In fact, as noted earlier, many interpret the statute to require the second evaluation to be conducted within 24 hours of the first, not necessarily within 24 hours of admission.

A larger complaint in Winston-Salem, however, is that no examination is required to be conducted after the first day or two in the respondent's period of detention. Many feel that it is important that an evaluation be done near the time of the hearing, so that the court will have current information about respondent's condition. Thus, some local physicians delay the second evaluation until nearer the time of the hearing; others conduct the second evaluation during the first few days of respondent's detention (but not necessarily within 24 hours of the first evaluation) and conduct a third evaluation shortly before the time

of the hearing. To the extent that the requirement that a second evaluation be conducted promptly is intended to provide an independent check on the findings of the first examiner, delaying the second examination may be unfair to the respondent. Requiring that a third evaluation be conducted probably will 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, 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 (qualified physician) have any mental health training or expertise. 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 we are not well enough informed about the availability of mental health professionals in other areas of the state, we will resist the temptation to recommend that the statute be amended to require that evaluations be conducted by persons with mental health training and/or expertise. People in Winston-Salem should be sensitive to the fact that not all qualified physicians have meaningful mental-health training or experience, however, and should insist that evaluations continue to be conducted by psychiatrists.

In a number of states, respondents in involuntary civil commitment proceedings are accorded a right to remain silent during the mental health evaluation. A federal court has ruled that the priviledge 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 (French v. Blackburn, 428 F. Supp. 1351 (1977)). Although other federal courts recently have recognized the applicability of the priviledge in commitment proceedings, we will refrain from recommending in this report that the privilege be made applicable in Winston-Salem. However, the question of whether the respondent should be informed of the way in which the information generated by the evaluation might be used is a more difficult one. Former involuntary patients in other cities speak of a sense of bewilderment and confusion that respondents experience during the initial stages of a commitment proceeding. They say that the "silent treatment" often given by staff of the detaining facility fosters resentment in the respondent and may act as a disincentive to cooperation with staff. In addition to these concerns is the question of whether the respondent's communications to the examiner are protected to any degree by a doctor-patient priviledge. Most scholars agree that little or no such priviledge 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 laws provide that the physician who evaluates the

respondent for the purposes of a commitment proceeding may not be the respondent's treating physician. In Columbus, Ohio, each respondent is examined by a "court doctor" and by an "independent doctor": the independent doctor is bound by the doctor-patient priviledge, whereas the court doctor is not. Several scholars have suggested that, so long as the patient is informed that the results of an examination might be used by a court in a commitment proceeding, it is acceptable for a treating physician to reveal his or her findings, but that, absent such a notification of purpose, the treating physician is in violation of ethical standards if he or she reveals examination findings. A psychiatrist at one of the facilities in Winston-Salem reported having had to deal with the question of doctor-patient priviledge. He said that, during a recent evaluation, a respondent confessed to having killed someone. Because the facility recognized a doctor-patient privilege, at least to some extent, it faced a dilemma. As a result of this incident, it is now policy at this particular facility for examining physicians to explain to respondents how statements made to them might be used.

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 is the failure 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, a careful weighing must be made of the extent to which the cost of the commitment process would increase and the legal protection and treatment interests of the respondent would be enhanced.

The professional literature suggests that independent examinations are important for two reasons: they provide an additional opinion in an area in which unreliable assessment is not uncommon, and they provide some 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 has little to draw on in developing a defense.

The cost of providing a 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 respondent, it is reasonable to presume that requests for such examinations would increase. However, our research in other states that provide a right to an independent examination at the government's expense suggests that respondents rarely request this examination even when they are notified of their right to it. Counsel is

aware that independent examinations usually extend the prehearing period and produce no new "evidence" unless real questions exist about respondent's condition. Thus, counsel usually advises respondents not to request independent evaluation except in cases for which it would be particularly valuable.

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 BY THE QUALIFIED PHYSICIAN DESCRIBED IN SECTION 122-58.6. (NO INDEPENDENT EXAMINATION NEED BE PROVIDED AS A CHECK ON THE INITIAL, "SCREENING" EVALUATION CONDUCTED PURSUANT TO SECTION 122-58.4).

F. PREHEARING TREATMENT

The North Carolina statute is strong in its recognition of a right to treatment and of a right to be free from unnecessary or excessive medication with drugs. As mentioned elsewhere in this report, a right to treatment for involuntary patients has been recognized by a number of appellate courts; and the use of medication as a patient management device is almost universally regarded as improper. 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 a strong feature, given the extraordinary intrusiveness of these procedures. The statutes, however, do not address the question of the respondent's right to refuse less intrusive treatment, and the policies of the facilities in Winston-Salem are not consistent on this question.

A number of states recognize the right of involuntary patients to refuse treatment except in emergency situations. In many states, emergency situations are limited to those in which a failure to treat would result in physical injury to the patient or others. The U.S. Supreme Court is expected to rule on the question of the involuntary patient's right to refuse treatment shortly in Rogers v. Okin, cert. granted, 49 U.S.L.W. 3788 (April 20, 1981). Furthermore, we understand that the North Carolina Supreme Court is expected to consider the question soon in the case of Willie M.

For the most part, questions concerning the right to refuse treatment have arisen in the context of the committed person. For respondents detained pending a hearing, the "right" arguably is more important, for two reasons: (1) at this stage, 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) 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 sometimes is difficult to determine whether a

respondent's appearance and behavior in court represent his or her true mental condition or are the result of medication, and that this makes it difficult to determine respondent's suitability for involuntary commitment.

RECOMMENDATION: PENDING A COMMITMENT HEARING, 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 RESPONDENT DURING THE PREHEARING DETENTION PERIOD AND RESPONDENT'S TREATING PHYSICIAN HAS ANY REASON TO BELIEVE THAT 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 COMMITMENT JUDGES INDICATING THE BEHAVIORAL EFFECTS OF PARTICULAR MEDICATIONS FREQUENTLY USED TO TREAT PSYCHIATRIC PATIENTS.

It was suggested by staff of a hospital in a different state that, when faced with a patient refusing medication, the physician should discuss with the patient the basis for his or her refusal and determine whether an alternative treatment might be agreeable to the patient. Often, patients who have been hospitalized and treated in the past are aware of particular benefits and side affects that they experience as a result of particular medications. By working with the patient, the physician frequently can arrive at a medication or other treatment that may be more appropriate for and acceptable to the patient than that prescribed initially. Also, if a physician discovers that a patient has a history of extensive treatment with a particular medication that has a risk of side effects with long-term use, the physician may wish to avoid prescribing that medication.

RECOMMENDATION: BEFORE THE RESPONDENT IS TREATED WITH MEDICATION, THE TREATING PHYSICIAN SHOULD MEET WITH THE RESPONDENT AND INQUIRE WHETHER THE RESPONDENT HAS BEEN TREATED WITH ANTI-PSYCHOTIC OR OTHER PSYCHOTROPIC MEDICATIONS IN THE PAST AND WHETHER, AS A RESULT OF THIS, RESPONDENT HAS A PREFERRED MEDICATION OR TREATMENT.

## G. CONVERSION TO VOLUNTARY STATUS AND RETENTION OF VOLUNTARY PATIENTS

Lawyers, judges, and mental health professionals in other cities have complained that persons who are picked up and taken against their will to a psychiatric facility frequently are coerced into becoming voluntary patients by threats that involuntary proceedings will be initiated if a voluntary admission is not agreed to. In some states, statutes have been enacted to prevent such coercion. The problem of coerced voluntary admission appears not to exist in Winston-Salem. In fact, a number of people in Winston-Salem complain that <u>too often</u> respondents in involuntary proceedings request and obtain conversion to voluntary status as a means of securing a speedier release from the hospital.

The legal and mental health communities in Winston-Salem seem to agree that respondent has no absolute right to convert to voluntary status and that approval of an application for such conversion is within the discretion of the treating physician and the court. (Committed persons may convert with the approval of the treating physician alone.) Some community representatives complain that respondents and patients are allowed to convert to voluntary status too frequently 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 respondents 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 is called for.

The procedures in Winston-Salem for dealing with voluntary patients who request release are unclear. Many people in Winston-Salem believe that voluntary patients who request release always are released and that this, coupled with the facilities' tendencies to grant respondents' requests for conversion to voluntary status in nearly all cases, provides a way out of the hospital for most persons committed involuntarily. Personnel in the facilities state that if a patient is dangerous (or otherwise meets the involuntary criteria), the facility will either 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 is important that facility personnel act to prevent the release of persons who meet the involuntary commitment criteria. Assuming that the practices in Winston-Salem are, in fact, as facility personnel describe them to be, no recommendations for change would appear to be in order. On the other hand, if the lay perception is more accurate, a change might be appropriate. Further objective study of this question would be necessary before a recommendation could be offered with any degree of confidence.

## H. 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 the legal interests of respondents and the economic interests of society. The procedure is especially valuable in the rural areas of the state, where it prevents the inappropriate transportation of respondents over long distances to detaining facilities. The law and practice regarding the respondent's status following a finding of noncommittability at the second examination are not so praiseworthy, however. People in Winston-Salem and at the John Umstead Hospital in Butner agree that if the physician's report indicates that the respondent

does not meet the commitment criteria, he or she will not be committed. Therefore, a requirement that a hearing be held in such cases seems unnecessarily wasteful. The practice in some facilities in Winston-Salem to retain the respondent pending the hearing despite a finding of noncommittability at the second examination is contrary to law and seems particularly inappropriate. While it might be argued that the few days of hospitalization that result from this practice are beneficial to persons who may be mentally ill but do not meet the involuntary commitment criteria, it is our opinion that any such benefit is too small and uncertain to justify the infringement on personal liberty and the economic cost to society that result from this practice.

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 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 say, 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 screen out cases not suitable for involuntary commitment, to protect against unreliable or mistaken diagnosis, or to detect a rapid improvement in respondent's condition, a failure to release respondent under such circumstances is 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 (and probably should if the initial examiner is the treating physician); but a finding of noncommittability by the second examiner should result in the discharge of respondent (as required by law) and the termination of proceedings against him or her (as demanded by logic and practicality). Prospective hearing participants should be notified of the discharge and termination so that 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. BEFORE MAKING A FINDING THAT THE RESPONDENT DOES NOT MEET THE COMMITMENT CRITERIA, THE PHYSICIAN CONDUCTING THE SECOND EVALUATION OF THE RESPONDENT SHOULD BE PERMITTED TO CONSULT THE PHYSICIAN WHO CONDUCTED THE INITIAL EVALUATION AND DETERMINE WHETHER THERE ARE FACTS OR OTHER EVIDENCE THAT WOULD RENDER A FINDING OF NONCOMMITTABILITY INAPPROPRIATE.

A number of community representatives in Winston-Salem unhappily report that when patients are released (prior to or following a hearing), family members and other interested parties often do not receive notification of the release. Facility personnel admit that they have no clear policies for providing notification upon discharge. To the extent that respondents are entitled to prevent the facility from notifying family members and others of their detention or commitment, it is reasonable to suggest that they should be entitled to prevent the hospital from notifying these persons of their release as well. If, as is recommended above, upon release of respondent prior to hearing, the facility notifies the court and the court, in turn, notifies respondent's counsel, the district attorney, the petitioner, and witnesses summoned to appear at the hearing, most necessary notifications will be taken care of. An additional question, however, is 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, perhaps because any significant threat would indicate sufficient dangerousness to warrant holding for a hearing, personnel of mental health facilities in other cities we visited feel that it is a vitally important question. In one city in particular, persons frequently are hospitalized as a result of their allegedly having made threats against public officials or other public figures. In these cases, facilities in the city have a policy that facility staff notify the person allegedly threatened immediately upon the patient's release. In order better to protect the safety of the community and the legal interests of the releasing facilities and their staff, a similar policy should be considered in Winston-Salem.

# CHAPTER VII. COUNSEL FOR RESPONDENT

Whether or not the court receives a complete picture of the respondent'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. This chapter is concerned with the right to representation by counsel, the manner in which counsel is provided for indigents, the role and responsibilities of counsel, counsel's access to information in possession of the state, procedures for handling respondent's rejection of assistance of appointed counsel, incentives and disincentives for counsel to be thorough, and competence of counsel.

## Description

### A. RIGHT TO REPRESENTATION BY COUNSEL

The law in North Carolina and the practice in Winston-Salem clearly recognize the right of all respondents to be represented by counsel. The North Carolina statutes provide 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 if financially able to do so 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. §122-58.7(c). As a matter of practice, every respondent in a commitment hearing in Winston-Salem is represented by counsel. Moreover, people in Winston-Salem estimate that 94% of respondents are represented by assigned counsel.

### B. THE MANNER IN WHICH COUNSEL IS PROVIDED FOR INDIGENTS

The North Carolina statutes provide that when a clerk or magistrate issues a custody order, he or she must inquire whether the respondent is indigent. §122-58.3. In Winston-Salem, when a petitioner meets with the clerk or the magistrate for the purpose of initiating a commitment proceeding, the clerk or magistrate asks the petitioner to complete two forms (contained in Appendix A) concerning the respondent's financial status and intention to retain private counsel. If the petitioner indicates either that respondent is indigent or that respondent does not intend 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 respondent meets the involuntary commitment criteria, the clerk appoints counsel.

The clerk maintains a list of private attorneys in Winston-Salem who are available for appointment in these cases. Reportedly, the clerk usually assigns counsel sequentially from the list but occasionally deviates from this procedure in order to assign a particular attorney to a case for which he or she is especially well suited. Each attorney is assigned three cases to be heard on a particular day. The clerk makes an effort to assign attorneys to 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 date. The clerk makes assignments by telephone and prepares an order of assignment (form contained in Appendix A) for the judge's signature. Although the statutes require that notice of the hearing be given to respondent's counsel at least 48 hours in advance of the hearing (§122-58.5), as a matter of practice in Winston-Salem, attorneys receive assignments anywhere from one to six days before the hearing.

The only qualification required of attorneys who are appointed to commitment cases in Winston-Salem is that they be members of the North Carolina Bar. Although there is no regular program of training for these attorneys, there is local interest in developing such a program. A seminar was held in Winston-Salem in July 1981 on the role of the attorney in involuntary civil commitment proceedings. A number of issues were addressed during the seminar, including the evidentiary weight of the medical affidavit, waiver of respondent's appearance at the hearing, physician liability, the role of the district attorney, access to medical records, and treatment alternatives. Speakers included a member of the Winston-Salem Bar, a District Court Judge, the Assistant Clerk of the Superior Court responsible for judicial hospitalizations, an Assistant District Attorney, three local psychiatrists, and the assistant director of the Mental Health Authority of Forsyth County and founder of an organization composed of relatives of patients. Reportedly, the seminar was well received and thought has been given to conducting similar seminars on a periodic basis in the future.

C. THE ROLE OF COUNSEL

The North Carolina statutes provide that the professional relationship of assigned counsel is to be the same as if counsel had been privately retained by the indigent person. §7A-450. No further information about counsel's role is specified by statute.

Most people in Winston-Salem seem to agree that counsel for respondents in commitment hearings in Winston-Salem generally assume the role of guardian ad litem, acting in what they perceive to be the best interests of respondent. Reportedly, it is extremely rare for an attorney to advocate aggressively to have his client released from the hospital. Frequently, attorneys will allow (and even encourage) their

clients to testify when they know that such testimony will result in commitment. One psychiatrist told us that "it is the doctors who want to have an adversary procedure; the attorneys just want to do what we tell them to."

While in Winston-Salem, research staff had the opportunity to attend commitment hearings, dine at some interesting restaurants, and observe the performances of several different attorneys. In a number of cases, 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 respondent's difficulties and his or her need for treatment. In one case, respondent's attorney told the court that respondent (whose presence counsel had waived) had asked him to represent to the court that respondent simply had a different life style; respondent's attorney indicated to the court that he did not necessarily agree that this was the extent of respondent's problem. In another case, 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 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 respondent had told him that he also thought respondent was dangerous.

Most people in Winston-Salem agree that the "best interests" position is the appropriate one for attorneys to take in involuntary commitment cases. A judge told us that he believed the proper role was somewhere between guardian ad litem and advocate. An attorney voiced the opinion that the central concern of respondent's counsel should be to ensure that respondent is not "railroaded" but that this effort should stop short of "fighting to get the person out of the hospital." Another attorney said that although the local bar feels that it is appropriate for counsel to act in the respondent's "best interests," he personally feels that 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 said that "it would be presumptive 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."

### D. THE RESPONSIBILITIES OF COUNSEL

The North Carolina statutes provide that, in addition to representing the respondent at the initial hearing, assigned counsel is responsible for 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, assigned counsel is discharged. If the respondent is committed to a community mental health facility, assigned counsel remains responsible for his or her

representation until either counsel is discharged by the court or the respondent is discharged from the community facility. §122-58.10. As a matter of practice in Winston-Salem, assigned counsel reportedly "never" pursue appeals or provide post-commitment representation.

Although the North Carolina statutes specify no other responsibilities of the respondent's counsel, it generally is expected in Winston-Salem that, at least once prior to hearing, counsel will meet with the respondent in the facility in which the respondent is detained pending the hearing. A local attorney told us that, in his opinion, the respondent's attorney is responsible for interviewing the respondent, the respondent's treating physician, and the petitioner prior to hearing. He admitted, however, that few appointed attorneys were so thorough.

### E. COUNSEL'S ACCESS TO INFORMATION IN POSSESSION OF THE STATE OR THE DETAINING FACILITY

There is no law in North Carolina specifically providing that counsel in commitment cases have 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 examining physicians. Hospital 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 permission. At another facility, records usually are available to respondent's counsel "because it is important that the attorney have all the information available" about respondent; however, a spokesperson at this facility indicated that if a particular attorney were "the Clarence Darrow type," physicians at the facility were less likely to be cooperative.

One of the attorneys with whom we spoke (perhaps the "Clarence Darrow type") indicated that he had had problems with access to records at all of 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 complained that physicians' reports often are not provided to the court much in advance of the time of the hearing and that, as a result, in order to review the report in a given case, it may be necessary for counsel to visit the mental health facility and inspect the facility's records. This 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 attorneys.

F. PROCEDURES FOR HANDLING RESPONDENTS' REJECTION OF ASSISTANCE OF APPOINTED COUNSEL

As indicated earlier, the law in North Carolina provides that respondents in involuntary commitment proceedings "shall be represented by counsel" (unless the basis for commitment is inebriety, in which case respondent may waive counsel if sober and capable of making an informed decision). §122-58.7(c). Few persons in Winston-Salem ever have seen or heard of a respondent rejecting the assistance of appointed counsel. One individual, however, said that he had seen it happen on rare occasions in the past and that it was viewed as a symptom of the respondent's mental illness, not as an assertion of legal rights. In each of these cases, he said, counsel continued to represent respondent.

G. INCENTIVES AND DISINCENTIVES FOR COUNSEL TO BE THOROUGH

The statutes in North Carolina present no clear incentives or disincentives for respondent's counsel to be thorough. Of course, as a practical matter, the impressions of the judges and the attorneys of the local bar with respect to counsel's performance serve as something of an incentive for counsel to conform to the style most appreciated by these individuals. It was suggested that because most of the judges and most of the bar believe that counsel should "not go overboard" with these cases, appointed attorneys rarely prepare or present a very extensive defense.

The relatively low compensation provided appointed counsel ($50 per case, except in highly unusual cases requiring an extraordinary effort on the part of the attorney) may serve as a disincentive for attorneys to be thorough. Several people expressed the opinion that, for $50 per case, an attorney could be expected to do little more than meet with respondent before the hearing, briefly review pertinent records, and represent respondent at the hearing--that any meaningful prehearing advocacy or serious effort to arrange for an outpatient placement of respondent would be too much to expect. However, the practice in Winston-Salem of assigning each attorney three cases for each hearing day and ensuring that the respondents in the cases are patients in the same mental health facility prehearing should serve as an increased incentive for counsel to engage in some prehearing advocacy.

H. COMPETENCE OF COUNSEL

Psychiatrists in Winston-Salem indicate that attorneys usually visit respondents prior to hearing, but not always. Attorneys in Winston-Salem suggest that the younger attorneys generally are more conscientious in their preparation--that they usually meet with their clients on a day prior to the hearing day, but that some attorneys wait until the day of the hearing to speak with their clients (in court) for the first time. One of the judges observed that the "best attorneys" go to the hospital and meet with their clients before the hearing. The police officers responsible for transporting respondents from the

treatment facilities to the hearing report that many respondents indicate to them during the trip to the courthouse that they have not yet met their attorneys.

A judge indicated that the large majority of attorneys in commitment cases basically understand the facts of the case, but that many do not understand the commitment statute. This opinion was echoed by psychiatrists in Winston-Salem. One psychiatrist characterized attorney competence in commitment cases in Winston-Salem as "close to zero." While this admittedly is hyperbole, it reflects a sentiment among Winston-Salem psychiatrists that the appointed attorneys do not represent their clients as well as they might.

In the hearings observed by the research staff, the attorneys appeared to be at least minimally prepared. All seemed to have met with their clients prior to the day of the hearing. Counsel waived the appearance of the examining physician in every case and did not challenge the physician's reports in any case.

## Strengths, Weaknesses, and Recommendations for Improvement

### A. RIGHT TO REPRESENTATION BY COUNSEL

The law in North Carolina and the practice in Winston-Salem regarding right to counsel are strong. The requirement that non-indigent respondents be represented by appointed counsel if they fail to retain private counsel is particularly praiseworthy, because it protects the legal interests of persons who cannot be presumed to be competent to represent themselves.

### B. THE MANNER IN WHICH COUNSEL IS PROVIDED FOR INDIGENTS

There are a number of different systems in different states 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, our experience in other jurisdictions having different systems suggests that, in many ways, assignment systems result in less effective advocacy. 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, it generally is true that only relatively new attorneys having little other work to do and limited legal experience take these cases. As a result, attorney competency generally is lower than it is in jurisdictions using different defender systems.

RECOMMENDATION: THE COURTS AND THEIR ALLIED AGENCIES IN WINSTON-SALEM SHOULD STUDY THE POSSIBILITY OF CREATING A NEW SYSTEM FOR PROVIDING COUNSEL TO INDIGENTS IN INVOLUNTARY COMMITMENT CASES. OTHER SYSTEMS THAT SHOULD BE INVESTIGATED INCLUDE THE TYPE USED IN NEW YORK (THE MENTAL HEALTH INFORMATION SERVICE, AN ADVOCACY ORGANIZATION RESPONSIBLE PRIMARILY FOR REPRESENTING THE INTERESTS OF PATIENTS IN PSYCHIATRIAC HOSPITALS), THE PUBLIC DEFENDER SYSTEM (USED, FOR EXAMPLE, IN CHICAGO, ILLINOIS), AND THE SPECIAL COUNSEL SYSTEM USED IN THE REGIONAL FACILITIES IN NORTH CAROLINA.

(We do not feel competent, without further study, to suggest precisely what sort of system would be best suited to the particular circumstances existing in Winston-Salem.)

The procedures used by the clerk or magistrate to determine whether or not a prospective respondent is indigent seem to be reasonably good. A number of people in Winston-Salem suggest that, for the purposes of determining whether respondent is entitled to counsel at state's expense, any more thorough an investigation than that which is presently conducted by the clerk or magistrate at the time that the affidavit is submitted would cost the state more than the $50 that assigned counsel usually is paid. Thus, the system probably is functioning now in the most effective manner that is possible.

The clerk's procedure for assigning attorneys sequentially from a list, except in extraordinary cases, seems fair both to local attorneys and to respondents. The policy of assigning three cases to each attorney for each hearing day, involving respondents all detained at the same facility prehearing is regarded locally as providing an excellent incentive for attorneys to make themselves available for assignment and to visit their clients before the day of hearings.

The occasional practice in Winston-Salem of disregarding the requirement that respondent's counsel be notified of respondent's hearing at least 48 hours in advance is a serious weakness in the commitment system in Winston-Salem. In order adequately to prepare respondent's case (meet with respondent, review legal and medical records, identify and interview potential witnesses, etc.), respondent's counsel should be given at least 48 hours notice. Counsel should not be required to continue a case in order to have time to prepare a defense, under ordinary circumstances.

RECOMMENDATION: ASSIGNMENT OF COUNSEL ALWAYS SHOULD BE MADE AT LEAST 48 HOURS BEFORE THE TIME SCHEDULED FOR HEARING.

As mentioned elsewhere in this report, the recent seminar presented in Winston-Salem on the role of the attorney in involuntary civil commitment proceedings was well received by representatives of both the legal and mental health professions. Many people suggested that similar seminars should be held on a periodic basis and that attendance should be required for all attorneys receiving appointments of commitment

cases. One psychiatrist suggested further that attorneys interested in receiving these appointments should be required to pass a test on the law and practice of civil commitment.

RECOMMENDATION: THE COURT SHOULD SPONSOR PERIODIC SEMINARS ON THE INVOLUNTARY CIVIL COMMITMENT PROCESS IN WINSTON-SALEM AND THE ROLE OF RESPONDENT'S COUNSEL IN THIS PROCESS. NO ATTORNEY SHOULD BE ELIGIBLE TO RECEIVE APPOINTMENTS OF COMMITMENT CASES UNTIL HE OR SHE HAS EITHER ATTENDED SUCH A SEMINAR OR VIEWED A FILM OR VIDEO TAPE OF SUCH A SEMINAR.

C. THE ROLE OF COUNSEL

Although most people in Winston-Salem seem to agree that the proper role for respondent's counsel is to act as a guardian ad litem (serving the "best interests" of respondent), it should be noted that Winston-Salem is not in the mainstream of contemporary legal thought in this regard. In the other cities in which we have conducted research, in the statutes and case law of many other states, and throughout the professional literature, it is clear that counsel are being directed to assume a strong advocacy role to represent their clients' stated interests. Moreover, it can be argued that because North Carolina law requires that assigned counsel represent respondent as though he or she had been privately retained (§7A-450), the guardian ad litem model may be legally insufficient.

The diagnosis of mental illness is widely regarded as an imprecise endeavor. Moreover, recent studies have shown quite convincingly that psychiatric predictions of future dangerous behavior are terribly unreliable--that predictions of dangerousness much more frequently are wrong than they are right. Because of this, it is inappropriate for anyone, particularly respondent's attorney, to accept without question psychiatric opinion that respondent meets the criteria for involuntary commitment. Indeed, psychiatrists in Winston-Salem believe that local attorneys much too readily accept what is contained in their reports. Given the difficulty psychiatrists have in assessing respondents' suitability for commitment, it is unrealistic to think that respondents' attorneys can know what is in their clients' best interests. This is particularly true in Winston-Salem, where appointed attorneys usually are inexperienced in mental health matters.

To the extent that the state is adequately represented in commitment proceedings and that the laws and procedures governing these proceedings are reasonable and fair, a strong advocacy representation by respondent's counsel should not make it any more difficult for the court to determine the most appropriate disposition for a case. Moreover, a more vigorous representation by respondent's counsel likely will be accompanied by a more vigorous representation by the district attorney, and, as a result, the court likely will receive more complete information about respondent's condition and the treatment programs, if any, that are appropriate.

Because the role of counsel has not been the subject of serious challenge in Winston-Salem, no major changes will be recommended in this report--but it should be stressed that this aspect of the commitment system has the potential for strong question and challenge. Pressures to change the role of counsel may arise in the near future and should not come as a surprise.

RECOMMENDATION: THE ROLE OF RESPONDENT'S COUNSEL SHOULD BE DISCUSSED AND EXPLORED BY THE WINSTON-SALEM LEGAL AND MENTAL HEALTH COMMUNITIES. SERIOUS ATTENTION SHOULD BE GIVEN TO THE NATIONAL TRENDS AND REASONS FOR HAVING COUNSEL ASSUME A STRONG ADVOCACY ORIENTATION.

D. THE RESPONSIBILITIES OF COUNSEL

The statutory requirement that counsel represent respondent at the initial hearing, on appeal, and during the period of commitment if respondent is committed to a local facility is a strong feature of the commitment law in North Carolina. However, as a matter of practice in Winston-Salem, it appears that counsel's service to respondent ceases at the conclusion of the initial commitment hearing. Reportedly, counsel virtually never discusses the question of appeal with respondent, and appeals of commitment orders are practically non-existent. Similarly, respondents committed to facilities in Winston-Salem reportedly receive no representation from their appointed attorneys. Further discussion of these issues and recommendations for improvement are presented later in this report, in the POSTHEARING CONCERNS section.

As mentioned elsewhere in this report, people in Winston-Salem generally agree that counsel for respondent should at least meet with respondent before the day scheduled for hearing. Indeed, it may be fair to presume that respondents whose attorneys fail to meet with them until the day of their hearings are denied the effective assistance of counsel. Attorneys who engage in such behavior should be subject to sanction.

RECOMMENDATION: COUNSEL FOR RESPONDENT SHOULD BE REQUIRED TO MEET WITH RESPONDENT AND DISCUSS 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 TO REPRESENT RESPONDENT. 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.

E. COUNSEL'S ACCESS TO INFORMATION IN POSSESSION OF THE STATE OR THE DETAINING FACILITY

The practice in Winston-Salem of allowing respondent's attorney access to information contained in respondent's court file compensates, to some extent, for the failure of the North Carolina commitment statutes

to guarantee respondent or respondent's counsel access to information in the state's possession. However, the policies of some of the local treatment facilities of restricting access to respondent's records is a weakness of the commitment system in Winston-Salem. Counsel should never be forced into a situation in which his or her first exposure to information about the respondent occurs during the state's presentation of its case. Given that any information provided to respondent's counsel becomes privileged, the facility can have some assurance that confidentiality will be maintained and that the information provided will not be used against the respondent. Finally, the competency of respondents in involuntary commitment proceedings to decide who should be permitted access to their records arguably is questionable. To deny respondent's counsel access to these records because respondent fails to give permission may, in fact, be unfair to the respondent.

RECOMMENDATION: RESPONDENT'S ATTORNEY SHOULD BE PROVIDED ACCESS TO RESPONDENT'S HOSPITAL RECORDS REGARDLESS OF WHETHER RESPONDENT HAS PROVIDED EXPRESSED PERMISSION.

Should facility personnel be reluctant to comply with this recommendation for fear of liability to the respondent (for revealing confidential information without permission), an advisory opinion from the State Attorney General or a statutory amendment approving of this procedure should be solicited or pursued.

The competent attorney who insists on reviewing every physician's report submitted to the court is frustrated if facility records are not accessible and reports are not received by the court until shortly before the hearing. Counsel should not be required to inspect the court records immediately before the hearing to review reports submitted on the final day. If a procedure can be developed whereby staff of the facilities are provided with the names of patients' attorneys, the following recommendation would be appropriate.

RECOMMENDATION: AT THE TIME THAT THE EXAMINING PHYSICIAN SENDS HIS OR HER REPORT TO THE COURT, HE OR SHE ALSO SHOULD SEND A COPY OF THE REPORT TO RESPONDENT'S ATTORNEY.

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

RECOMMENDATION: RESPONDENT'S COUNSEL SHOULD MAKE AN EFFORT TO NOTIFY IN ADVANCE PERSONNEL OF A FACILITY WHEN HE OR SHE WISHES TO SPEAK WITH A PHYSICIAN AT THE FACILITY; UPON RECEIVING SUCH NOTIFICATION, THE FACILITY PERSONNEL SHOULD ATTEMPT TO ARRANGE FOR THE PHYSICIAN TO BE AVAILABLE TO MEET WITH RESPONDENT'S COUNSEL.

## F. PROCEDURES FOR HANDLING RESPONDENT'S REJECTION OF THE ASSISTANCE OF APPOINTED COUNSEL

The statute's requirement that respondent be represented by counsel (unless the grounds for commitment are inebriety and respondent is found to be competent) would seem to deny respondent the option of representing himself or herself. Although the Supreme Court has recognized a qualified right of criminal defendants to represent themselves if they are competent to waive the right to counsel, the North Carolina procedure in civil commitment cases probably is reasonable, given that the competency of allegedly mentally ill respondents to waive the right to counsel always is questionable. The general reasonableness of the North Carolina law in this area, coupled with the fact that respondents in Winston-Salem rarely attempt to reject the assistance of counsel, suggests that further discussion would be wasteful.

## G. INCENTIVES AND DISINCENTIVES FOR COUNSEL TO BE THOROUGH

There is a great likelihood that the relatively low compensation provided to appointed attorneys acts as a disincentive for counsel to be thorough. However, the practice of assigning three cases to each attorney for each hearing day remedies this to some extent. The occasional award of a higher fee to attorneys who demonstrate having devoted an extraordinary amount of time to a case may be seen as an incentive for counsel to be thorough. However, few judges or attorneys in Winston-Salem seem to be aware of this procedure. To the extent that the procedure might serve as an incentive for respondent's counsel to investigate particular defenses or otherwise more thoroughly prepare respondent's case, it is important that members of the local bar be aware of it. Should higher awards become more commonplace, the cost of the commitment system may increase. But, given the importance of an adequate legal representation to the liberty interests of the respondent, the increase may be warranted. Further, to the extent that additional efforts by defense counsel result in fewer commitments, the costs of treatment are saved.

RECOMMENDATION: THE JUDGES OF THE DISTRICT COURT SHOULD DISCUSS AND EXPLORE THE POSSIBILITY OF ESTABLISHING GUIDELINES FOR ORDERING HIGHER-THAN-USUAL FEES TO COUNSEL FOR RESPONDENTS IN INVOLUNTARY COMMITMENT PROCEEDINGS AND SHOULD NOTIFY THE LOCAL BAR OF ANY GUIDELINES ESTABLISHED.

People in Winston-Salem are unaware of any procedures for compensating attorneys representing respondents on appeal. This probably is due to the fact that appeals virtually never are pursued, which, in turn, probably is at least partly due to the fact that attorneys do not know whether or how much they will be paid for pursuing an appeal. Further discussion of this issue and a recommendation for improvement are presented in THE RIGHT OF APPEAL, in the Posthearing section of this report.

## H. COMPETENCE OF COUNSEL

(See discussion and recommendations elsewhere in this report concerning sanctions against respondent's attorney for failure to meet with respondent on a day prior to the hearing day and concerning mandatory attendance at periodic seminars sponsored by the court on the topic of involuntary commitment.)

# CHAPTER VIII. THE HEARING

It is at the commitment hearing that the various pieces of information about the respondent generated during the prehearing processing of the case, including petitioner's allegations, witnesses' statements, physicians' opinions, and legal considerations, are fitted together for independent assessment by a judge. Whether the pieces fit well and present a fair and complete picture of 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.

## Description

### A. GENERAL CONSIDERATIONS

It is both the law in North Carolina and the practice in Winston-Salem that every respondent in a commitment proceeding have a hearing before the district court within ten days of the day he or she is taken into custody (subject to continuance upon motion of respondent's counsel). §122-58.7(a). In Winston-Salem, even during holiday seasons (when court may not be sitting on its usual day), arrangements reportedly are made for hearings to be held within the ten day period. (For further discussion of the timing of the hearing, see PREHEARING DETENTION, in the Prehearing section of this report.)

The clerk of the Superior Court is required by statute to notify the respondent and the respondent's attorney at least 48 hours in advance of the hearing, unless notice is waived by respondent's counsel. §122-58.5. Additionally, the court must provide notice of the hearing to the petitioner at least 48 hours in advance, unless waived. §122-58.20. Reportedly, these notifications are made in Winston-Salem, but not always within 48 hours of the hearing.

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.

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. §122-58.7(f). Hearings are to be closed to the public, unless the respondent requests otherwise. §122-58.7(g). 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.

B. THE CRITERIA AND STANDARD OF PROOF FOR INVOLUNTARY COMMITMENT

The statutes in North Carolina provide that before a commitment may be ordered, the court must find, by clear, cogent, and convincing evidence, that the respondent is mentally ill or inebriate and dangerous to himself or others, or mentally retarded and, because of an accompanying behavior disorder, dangerous to others, The court must record the facts which support its findings. §122-58.7(i).

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." §122-36(d). 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." §122-36(c). A mentally retarded person is defined as one "who has significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during his developmental period." §122-36(e). "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." §122-58.2

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 facia inference that the person is unable to care for himself . . .." 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. 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. §122-58.2(1). 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 adhered to by the district court judges in Winston-Salem. In the hearings observed by the researchers from the National Center for State Courts, the judge specified in his commitment orders the criteria satisfied and the facts supporting his findings.

C. THE ROLE OF THE DISTRICT ATTORNEY

North Carolina statutes provide that the assistant attorneys general assigned to the state's four regional psychiatric facilities are responsible for representing the state's interests at commitment hearings, rehearings, and supplemental hearings held at these facilities. §122-58.24. The statutes, however, do 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. Several people stated that when this happens, the district attorney usually allows the private attorney to present the case for the state. One attorney, however, indicated that the district attorney typically continues to be the state's primary representative in this situation--that attorneys for petitioners participate only to the extent that petitioners require their assistance for some reason.

D. THE ROLE OF THE JUDGE

Although the law in North Carolina does not specify a particular role for judges to assume in civil commitment cases, it is generally

agreed in Winston-Salem that the proper role of the judge 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 respondent is found to meet the criteria, determine whether outpatient or inpatient treatment is appropriate.

Judges in Winston-Salem typically do not ask many direct questions of the witnesses, but tend, rather, to allow the attorneys to elicit the testimony. In the hearings observed by the National Center research staff, the judge generally did not examine witnesses; however, he did ask a few questions intended to clarify information already in evidence. The judge ruled on objections when they were made by counsel but did not find, sua sponte, that evidence that may have been objectionable was inadmissable. (Of course, the judge is free to disregard evidence that he or she feels is not competent.)

## E. THE PRESENCE OF THE RESPONDENT AT THE HEARING

The law in North Carolina provides that counsel may in writing waive the presence of the respondent with consent of the court. §122-58.7(d). As a matter of practice in Winston-Salem, the presence of respondent frequently is waived. One judge estimated that waivers occur in 50% of the cases. Waivers are submitted to the court in writing, signed by respondent's counsel. Respondent is not required to sign the waiver. However, one attorney stated that, in order to protect himself, he always has respondent sign a form indicating that the respondent agreed to the waiver.

Reportedly, attorneys routinely waive respondent's appearance in three situations: when respondent is so decompensated 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 release of respondent (e.g., the physician's report recommends discharge), and when respondent expresses a wish not to resist commitment (either has converted to voluntary status or simply does not object to involuntary treatment). Some respondents reportedly ask their attorneys to waive their presence because they prefer to avoid witnessing their family and friends describe their aberrant behavior in a courtroom full of people.

As indicated earlier in this report (see, PREHEARING TREATMENT, in the Prehearing section), respondents frequently are under the influence of medication during their hearings. Some people in Winston-Salem report that respondents often are medicated to the extent that they do not appear to understand what is going on in court. This research staff, observing hearings in Winston-Salem, was unable to tell whether the respondents we observed were under the influence of medication. Gross behavioral abnormalities were not easily apparent among respondents. It should be noted, however, that staff observed few respondents presenting oral testimony, spoke personally with no respondents, and, in any event, are not trained to make such observations.

F. THE PRESENCE OF THE EXAMINING PHYSICIAN AT THE HEARING

The North Carolina statutes provide that certified copies of physicians' reports and medical records of the mental health facility are admissible in evidence but respondents retain the right to confront and cross-examine witnesses. §122-58.7(e). As a matter of practice in Winston-Salem, physicians almost never appear in court to testify. One judge estimated that fewer than 20 physicians have testified in commitment cases in his court in the last seven years.

It generally is expected that respondent's counsel will stipulate to the medical report profferred by the district attorney; in those cases in which respondent's counsel refuses to stipulate to the report, the judge either will ask respondent's counsel to agree to a continuance for one week (such a continuance not permissible over the objection of respondent) or will 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 in court. 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, respondent's attorney can almost guarantee respondent's discharge. Judges in Winston-Salem are said to have admonished attorneys for refusing to stipulate, criticizing them for failing to use the prehearing period to work out informally before the hearing any problems they may have had with the physician's report.

Several of the Winston-Salem court staff complain that physicians' reports usually are hand written and sometimes are illegible. In one case observed by this research staff, respondent's counsel had difficulty reading a report to which he had stipulated. 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 the reports are so incomplete that they present a small obstacle to the attorney determined to have his or her client released, and that, therefore, from a defense standpoint, it may make more sense to stipulate to the report than to demand the right to cross-examine the physician.

G. 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 regarding respondent's behavior and suitability for hospitalization, outpatient care, or release.

H. PUBLIC ACCESS TO HEARINGS

The North Carolina statutes provide that hearings are to be closed to the public, unless the respondent requests otherwise.

§122-58.7(g). 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, can not hear them because of the partition. (One attorney claims that the partition is not entirely soundproof; the research staff made no effort to verify this.) 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.

## I. CONTINUANCES

Statutes in North Carolina allow for continuances of up to five days each on the motion of the respondent's counsel. §122-58.7(a). The statutes provide further that if a 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 for up to seven days for the production of evidence to help in determining disposition. Continuances of this type may be granted on motion of respondent's counsel or the state's attorney, or on the court's own motion. §122-58.8.

In practice, continuances are rare in Winston-Salem. Judges recognize that only the respondent may move for a continuance (except in the situation in which the judge lacks sufficient information about a respondent's suitability for outpatient treatment). One judge reported that, in his court, continuances are not granted unless both sides agree to them.

As indicated elsewhere in this report, in situations in which respondent's counsel refuses to stipulate to a medical report, the judge may delay hearing a case for a very short period of time (not beyond the 10-day prehearing period) so that arrangements might be made for the physician to attend the hearing. These situations arise infrequently, and, since the delay never serves to continue the case beyond the 10-day prehearing period, people in Winston-Salem refer to these delays as "adjournments" and consider them not subject to the continuance regulations.

## J. RULES OF EVIDENCE AND RULES OF PROCEDURE

Although commitment hearings in Winston-Salem generally are conducted less formally than trials in other matters are, 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 that the attorneys rarely object.

The judges indicate that evidence of previous commitments frequently is presented in hearings with no objection from respondent's counsel. Indeed, evidence of previous commitments often is contained in

the medical reports to which respondents' counsel 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, a good argument can be made that it is irrelevant; and few would deny that it is prejudicial. Moreover, the statutes do provide that evidence of previous voluntary admissions is inadmissable. §122-56.6.

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

K. THE QUESTION OF RESPONDENT'S COMPETENCY TO MAKE TREATMENT DECISIONS

The North Carolina statutes provide that an involuntary commitment "shall in no way affect incompetency proceedings . . . ." §122-55. 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.

L. THE PRESENTATION OF A TREATMENT PLAN

North Carolina statutes provide that a written treatment or habilitation plan must be formulated within thirty days after respondent's admission to a treatment facility. §122-55.6. Treatment plans typically are not presented at hearings in Winston-Salem. One judge reports that private hospitals occasionally present a treatment plan but that the public hospitals never do.

M. 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., respondent's commitment must be to the least restrictive program that is appropriate). The North Carolina statutes seem to recognize less restrictive alternatives primarily as a placement concern of the commitment order, if they recognize them at all. There is no statutory provision in North Carolina requiring the court to find that no less restrictive alternative exists before committing someone to involuntary treatment. The law does provide, however, that, upon a finding that respondent meets the commitment criteria, the court may order treatment, inpatient or outpatient, or a combination of both, at a public or private mental health facility. Before ordering outpatient treatment, the court

must make findings of facts as to the availability and appropriateness of the outpatient treatment program. §122-58.8. The law requires that committed persons be discharged as soon as a less restrictive mode of treatment is appropriate. §122-58.1.

People in Winston-Salem report that the judges view less restrictive alternatives as a question of whether to commit someone found to meet the commitment criteria to inpatient treatment or to outpatient treatment. The research staff were told that community care programs of the sort contemplated by the notion of less restrictive alternatives simply do not exist in Winston-Salem. However, in one of the hearings that the staff observed, respondent's counsel presented evidence that a community "teen challenge" center offered a program of care that was appropriate and available to accomodate respondent's disorder, and the court allowed the respondent to participate in the program in lieu of involuntary commitment.

When talking about less restrictive alternatives with lawyers and psychiatrists in Winston-Salem, the conversation seems invariably to turn to the viability of court-ordered outpatient treatment. The court reportedly does not often order outpatient treatment because of difficulty in enforcing it. A couple of judges, however, report that, although the court has little authority to require that respondents comply with the terms of their outpatient programs ("we don't use contempt for mentally ill persons"), the "suggestive power" of the court often was effective in persuading respondents to comply. The law in North Carolina provides for a special, "supplemental hearing" procedure for dealing with respondents who fail to comply with the terms of an outpatient program. §122-58.3(c). The procedure allows the director of a mental health facility to bring an action to have a respondent who fails to comply with an outpatient program ordered into inpatient treatment. 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 a custody order to a law-enforcement officer to take the respondent into custody and transport him or her to 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 10 days of the time that 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 repondent;

(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 90 days running from the date of the order. This supplemental hearing procedure is not used in Winston-Salem reportedly because the requirement that an attorney general be involved makes it more cumbersome that simply beginning a new commitment proceeding. In practice, though, new commitment proceedings rarely are begun in these cases either.

N. 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 judges may not specify a mandatory minimum treatment period or particular treatment modalities to be used by the facility.

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

## Strengths, Weaknesses, and Recommendations for Change

A. GENERAL CONSIDERATIONS

The requirement that hearings be held in every case (as opposed merely to providing respondent with the right to request a hearing, as is the procedure in a few states) is a strong feature of the North Carolina law and procedure. Indeed, it is unrealistic to presume that respondents in civil commitment proceedings have the capacity to make intelligent decisions concerning the appropriateness of contesting their commitments in court. Some people in Winston-Salem suggest that it perhaps is not so important that all the due process protections be accorded because the local facilities, in fact, do not abuse the rights of patients. But most feel strongly that the hearing, at least, is essential to guard against the possibility that a person might be "put away" unjustly.

The requirement that hearings be held within ten days of the day respondent is taken into custody probably is reasonable, given the way in which cases are processed before the hearing. Some states require that a probable cause hearing be conducted soon after the custody taking to

guard against patently 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 protect against this. (For further discussion of the timing of the hearing, see, PREHEARING DETENTION, in the Prehearing section.)

The provisions requiring that respondent, respondent's counsel, and the petitioner be notified of the hearing at least 48 hours in advance are praiseworthy. The fact that in some cases respondent's counsel is not appointed within the 48-hour period should be considered a serious problem. This matter is discussed further, and recommendations are presented, elsewhere in this report (see, THE MANNER IN WHICH COUNSEL IS PROVIDED FOR INDIGENTS, in the Counsel section).

The notification of petitioners is a particularly strong feature of the commitment process in Winston-Salem. People with whom we have spoken in other cities complain bitterly that petitioners often are not informed when hearings are to be held and, therefore, are unable to participate in the proceedings. Although petitioners in Winston-Salem concede that they receive notification of the hearing date, they complain that it is difficult to find out anything else about a case while the case is pending. These individuals are particularly upset by the failure of facilities to notify them when respondents are released prior to hearing (see, PREHEARING DISCHARGE, in the Prehearing section).

North Carolina is among a small minority of states that do not provide respondent with a right to a jury trial. People in Winston-Salem seem unconcerned about this, however. Moreover, people with whom we have spoken in other cities where jury trials are available indicate that respondents virtually never elect to have their cases heard by a jury. We make no recommendation on this matter.

The practice in Winston-Salem of holding hearings in a courtroom is not fully in keeping with the spirit of the North Carolina statutes. However, it is extremely 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 chapter.

## B. THE CRITERIA AND STANDARD OF PROOF FOR INVOLUNTARY COMMITMENT

The criteria for commitment in North Carolina are quite consistent with commitment criteria in other states. The standard of proof--clear, cogent, and convincing--is the same as that required by the U.S. Supreme Court in Addington v. Texas, §441 U.S. 418 (1979). There is general agreement in Winston-Salem that the criteria are workable. One psychiatrist opined 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 low reliability with which predictions of violent behavior are made. (The professional literature is rife with demonstrations that predictions of violent behavior are wrong much more frequently than they are right.) The psychiatrist stated that, in his opinion, very few respondents in Winston-Salem truly are dangerous. He said that when he began conducting evaluations of respondents in commitment cases a few years ago, he was reluctant to find that anyone met the criteria for commitment. He said that, under pressure from the community, however, he now has become "more liberal" in recommending commitment for persons under the dangerousness criterion. He suggested that if dangerousness is, indeed, the appropriate criterion for commitment, many people in Winston-Salem are being committed inappropriately. Given this sort of talk, it may be possible that some people in Winston-Salem do not fully appreciate the meaning of dangerousness as it is defined in the statute--they may think of dangerousness solely in terms of respondent's propensity to comit a violent act and not be sufficiently sensitive to the part of the definition describing someone who simply is unable to care for self. It is important that everyone participating in the commitment process in Winston-Salem be fully knowledgeable of what the statutes provide, both procedurally and substantively.

### C. THE ROLE OF THE DISTRICT ATTORNEY

Although not provided for 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 and is stated plainly throughout the professional literature that the presence of a state's attorney is essential in commitment hearings, if for no other reason than to ensure that the judge will not have to assume the role of "prosecutor" in these cases. Moreover, to the extent that respondent's counsel is a zealous advocate, the balance of the proceeding can be maintained only if the state also is zealously represented.

In practice, the district attorney does not 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 adversary system of law is based on a balanced presentation of the two sides of an issue, a strong advocacy position by respondent's counsel or the district attorney will demand a response in kind.

With regard to the practice of allowing petitioners' attorneys to represent the state, we have little comment. No one in Winston-Salem seems to object to this practice. Two potential problems can be

identified, however. First, if the petitioner's attorney advocates vigorously for hospitalization, the respondent may be at a serious and unjustifiable disadvantage if assigned counsel acts as a guardian ad litem. Second, to the extent that a particular petitioner's motives in proceeding against 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.

D. THE ROLE OF THE JUDGE

The role that the judges in Winston-Salem assume--that of neutral and detached hearing examiner--is generally applauded people in Winston-Salem and is the role that the professional literature suggests commitment judges should assume. For a discussion and recommendations concerning the judge's role in enforcing the rules of evidence and procedure, see, RULES OF EVIDENCE AND RULES OF PROCEDURE, in this section.

E. THE PRESENCE OF RESPONDENT AT THE HEARING

While many people in Winston-Salem believe that the frequent practice of waiving respondent's appearance at the hearing is appropriate, either as a recognition of respondent's wishes or as an expression of concern for respondent's emotional stability, others are quite 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 had a chance to hear and confront the "accusors." One local psychiatrist suggested that it is "fundamentally unfair" of respondent's counsel to waive respondent's presence. This psychiatrist said that being present at the hearing would threaten the emotional stability of few respondents. Rather, he suggeted, respondent's participation in all stages of the process has therapeutic value.

The professional literature indicates that, for some respondents, attendance at a hearing helps to dissolve delusions that the respondent's family is conspiring to have him or her "put away" unjustly. It is suggested that the hearing presents a fact-related basis on which respondent might understand why treatment is being ordered, which can be a useful starting point for therapy.

Allowing respondent's counsel to decide whether or not respondent should attend the hearing is particularly troublesome, because many appointed attorneys have limited legal experience and few have any experience with the mentally ill. 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 competence of these individuals to make such a decision is questionable.

Finally, it is important that respondent be present at the hearing so that the judge will have an opportunity to observe the respondent's behavior and consider the respondent's expressed wishes. Requiring the respondent's presence should reduce the likelihood that the judge would either commit unnecessarily or release improperly.

Although it may increase the cost of the commitment system, requiring that respondents be present at their hearings would significantly enhance their legal protections, may be therapeutic, and would enable the court to dispose of cases in a more informed manner.

RECOMMENDATION: RESPONDENT'S ATTENDANCE AT HIS OR HER HEARING SHOULD BE MANDATORY UNLESS RESPONDENT'S ATTENDING PHYSICIAN STATES IN WRITING THAT RESPONDENT'S APPEARANCE IN COURT WOULD SUBSTANTIALLY IMPAIR RESPONDENT'S MENTAL OR EMOTIONAL STABILITY OR WOULD SERIOUSLY THREATEN THE SAFETY OF OTHERS.

There is much debate in the professional literature about the propriety of allowing respondents to appear in court under the influence of medication. Some suggest that medication enables the respondent better to 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 respondent's behavior in court accurately reflects his or her mental condition or is a consequence of medication. Further discussion of this issue and a recommendation are presented in PREHEARING TREATMENT, in the Prehearing section.

F. THE PRESENCE OF THE EXAMINING PHYSICIAN AT THE HEARING

The routine absence of any mental health professional at the commitment hearing is perhaps the biggest difference between commitment proceedings in Winston-Salem and commitment proceedings in other cities throughout the country. Our research suggests that, in most states, the examining physician or some other mental health professional almost always is available in court to testify at the commitment hearing.

The question of whether the examining physician should be required to attend the hearing is a controversial one in Winston-Salem. Many people in Winston-Salem believe that if psychiatrists were required to attend hearings, some psychiatrists would be reluctant to recommend commitment, in order to avoid hearings. These people suggest that the notion of requiring the physician's attendance is unrealistic. However, some psychiatrists in Winston-Salem believe that examining physicians should attend hearings and present live testimony. One psychiatrist voiced the opinion that the current practice amounts to a medical model for commitment decision-making--that, because physicians' reports routinely are stipulated to, the recommendations of the physicians generally control the outcomes of the cases. This psychiatrist said that

he believes that too much credence is given to the medical reports. He said that if examining physicians were required to present their findings in open court, the court would have a better opportunity to assess the information on which the physician relied in arriving at his or her findings and make an independent determination of whether this information justified a commitment. This psychiatrist stated that he simply was not comfortable with the responsibility of making what he sees as the social decision of who should (or should not) be committed to treatment. He said that he felt that this was a decision for the court to make. Another psychiatrist stated that although he agrees that examining physicians should appear in court to present their findings, he 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. However, because there are three facilities in Winston-Salem that function as prehearing detention facilities, this practice would require that hearings be conducted at least three times per week. Most would agree that such a system would be terribly cost-inefficient.

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 USED TO ENABLE EXAMINING PHYSICIANS TO PRESENT THEIR TESTIMONY AND SUBMIT TO CROSS EXAMINATION BY TELEPHONE. SUCH A SYSTEM SHOULD INCLUDE RECEPTION, TRANSMISSION, AND AMPLIFICATION EQUIPMENT CAPABLE OF ALLOWING ALL OF THE PARTICIPANTS IN THE HEARING TO HEAR THE TESTIMONY OF THE EXAMINING PHYSICIAN AND DIRECT QUESTIONS TO HIM OR HER. SHOULD THE COURT DECIDE NOT TO USE SUCH A SYSTEM, IT SHOULD REFUSE TO ALLOW RESPONDENT'S COUNSEL TO STIPULATE TO THE REPORT OF THE EXAMINING PHYSICIAN ABSENT A REPRESENTATION BY RESPONDENT'S COUNSEL THAT HE OR SHE DISCUSSED THE POSSIBLE CONSEQUENCES OF THE STIPULATION WITH RESPONDENT AND RESPONDENT ACQUIESCED IN THE STIPULATION.

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

RECOMMENDATION: ALL REPORTS SUBMITTED TO THE COURT BY EXAMINING PHYSICIANS SHOULD BE TYPED.

G. THE PRESENCE OF THE PETITIONER AND WITNESSES AT THE HEARING

The fact that petitioners almost always are present at hearings to testify is a strong feature of the Winston-Salem commitment process. Our research in other cities has revealed that the testimony of

petitioners often is not available to the court and, as a result, the allegations of petitioner typically enter into evidence (if at all) as hearsay in the examining physician's testimony. The court in Winston-Salem should continue to encourage the attendance of petitioners in these cases.

H. PUBLIC ACCESS TO HEARINGS

The statute 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 implement strictly in practice. 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 forseeable detrimental effect on 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 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. To the extent that observers are able to hear the proceedings as well as see them (as has been suggested), the requirement clearly is violated. It generally is accepted that respondents have a legitimate interest in privacy during the commitment hearing. It is not so clear what benefits derive from the practice of allowing the public to view (and possibly listen to) the hearings.

RECOMMENDATION: MEASURES SHOULD BE TAKEN TO ENSURE THAT THE PUBLIC CAN NEITHER VIEW NOR LISTEN TO COMMITMENT HEARINGS.

It may be possible to implement this recommendation by simply installing heavy draperies over the glass partition between the hearing participants and the public.

The practice of seating other respondents in the courtroom within earshot of the proceedings seems to be in violation of 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 it may represent 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.

## I. 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 commitment system and is particularly important given that the prehearing hold may be relatively long to begin with (up to 10 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.

## J. 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 so 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, it may be argued that these concerns are academic; however, to the extent that counsel for respondent and the district attorney fail to make objections (which we were told is frequently the case), 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 TESTIMONY THAT IS HIGHLY OBJECTIONABLE IS GIVEN OVER NO OBJECTION, THE COURT SHOULD ALERT COUNSEL THAT RULES OF EVIDENCE SHOULD BE BETTER FOLLOWED.

## K. THE QUESTION OF RESPONDENT'S COMPETENCY TO MAKE TREATMENT DECISIONS

In some states, the court makes a finding during the commitment hearing as to the respondent's competency to make treatment decisions (i.e., refuse treatment) once committed. In states where involuntary patients are accorded the right to refuse treatment once committed, a determination at the commitment hearing regarding respondent's competency is quite useful. Present law in North Carolina provides that a commitment shall in no way be taken as an adjudication of incompetency, but 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 judicial procedure for determining incompetency were followed during the hearing).

No one in Winston-Salem suggested to these researchers that a serious problem exists with committed persons exercising a right to refuse treatment. Thus, it probably is unnecessary to consider developing procedures for the determination of the competency question during the commitment hearing. However, should this become more of a problem in the future (should the U.S. Supreme Court recognize a right to refuse treatment, for instance), the development of such procedures might be considered.

## L. THE PRESENTATION OF A TREATMENT PLAN

The criteria for involuntary commitment in a number of states require a showing that respondent's debilitating condition is one for which appropriate treatment is available. The U.S. 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. O'Connor v. Donaldson 422 U.S. 563 (1975). 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 respondent's condition. However, as was pointed out to the research staff in all of the cities in which we studied commitment procedures, it is optimistic to think that a meaningful treatment plan can be constructed during a short prehearing hospitalization period. Because of this, because the involuntary commitment criteria in North Carolina do not require a showing that respondent is treatable, and because the local facilities as a matter of practice develop treatment plans for their patients and regularly update these plans during the period of hospitalization, the fact that treatment plans are not often presented at hearings in Winston-Salem probably is of no profound significance.

## M. THE ROLE OF LESS RESTRICTIVE ALTERNATIVES

Statutes in a number of states provide that a court may not commit to involuntary treatment anyone for whom a less restrictive alternative is appropriate. Statutes in some states provide that, upon a finding of committability, the court must commit to the least restrictive treatment facility or program that is appropriate. Statutes in a few 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 specifically to 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 respondent nor those of society are satisfied when respondent receives treatment that is more intrusive and more expensive

than is necessary to accommodate his or her disorder. Given that North Carolina law requires treatment facilities to release involuntary 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; but, unless the court is required, before 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 is too easily 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 is too easily overlooked.

RECOMMENDATION: BEFORE ORDERING INVOLUNTARY TREATMENT, THE COURT SHOULD CONSIDER WHETHER ANY LESS RESTRICTIVE ALTERNATIVE WOULD BE APPROPRIATE TO ACCOMODATE 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 THAT IT WAS FOUND NOT TO BE APPROPRIATE.

The professional literature suggests that the state's attorney should be 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. This responsibility is placed by statute on the state's attorney in many states. Our research in states with such requirements, however, reveals that, in practice, the state's attorney usually is not aware of the alternatives that exist in the community and conducts little or no such investigation. While it is true that the state's attorney should take this responsibility more seriously, the practical fact that he or she does not suggests that the state's attorney should not be solely responsible for this investigation. "Justice" would best be served if, in addition to, and regardless of, any responsibility that the state's attorney may have to investigate less restrictive alternatives, respondent's attorney were 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 that might be 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 office of the court and could be

made available to assigned counsel upon request. Professionals who are actively involved with the delivery of social services in the city can be and should be called upon to assist in identifying community treatment programs and making this information available to a designated representative of the court. The local Mental Health Association might be particularly well equipped to provide such assistance. The information generated should be available at the courthouse for the use of prospective petitioners, respondents' attorneys, and the 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 COMMITMENT FOR RESPONDENTS IN COMMITMENT PROCEEDINGS. IT SHOULD BE THE RESPONSIBILITY OF 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 said that he would recommend outpatient treatment much more frequently than he did "if the judges would ever order outpatient treatment." This psychiatrist said that, in many cases, inpatient care is not very useful because the patient's symptoms rapidly will remit under medication and the patient will be quickly discharged, only to stop taking the medication and deteriorate to the point where further inpatient hospitalization is required. If judges more often would order outpatient treatment, he suggested, fewer cases would return to court because longer-term treatment could be provided.

The difficulty in enforcing respondent's compliance with the terms of an outpatient program is a serious problem to which there are no handy solutions. However, if the mechanisms for converting non-compliant involuntary outpatients to inpatient status were more frequently used and if respondents ordered into 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, 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 <u>not</u> appropriate and inpatient treatment should be ordered.

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 commitment cases in Winston-Salem to discharge the responsibilities placed by statute on the attorney general (as is done, essentially, for the purpose of prosecuting commitment cases), 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-COMPLAINT, 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.

## N. THE COURT'S ROLE IN DETERMINING PLACE OR CONDITIONS OF TREATMENT

A few people in Winston-Salem suggest that the court should have the discretion to commit respondents for mandatory minimum periods of treatment. The clear majority of people, 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--to leave postcommitment treatment decisions in the hands of mental health personnel--are in line with procedures in other states and seem to be entirely satisfactory.

# CHAPTER IX. 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 respondent was 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 patient's rights arises. This chapter discusses this question and others that may come to the attention of the court following the initial commitment hearing.

## Description

### A. NOTIFICATION REQUIREMENTS

If the court orders outpatient treatment, a copy of the court order is required by law to be sent to the outpatient treatment facility to which the respondent was committed. §122-58.8. No notification is required upon commitment of respondent to inpatient treatment. If the court finds that the commitment criteria are not met, it is required by law to discharge the respondent and provide notification of the discharge to the facility in which the respondent was last a patient. §122-58.8. 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. §122-58.13.

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, research staff were 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 frequently, as a practical matter, 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 respondent objects. A spokesperson at another facility indicated that such notification is not provided unless requested by respondent. When an involuntary patient is admitted to the John Umstead Hospital, staff of 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 restrictions, notifications of the patient's discharge are sent to the patient's immediate family and staff of the community mental health facility in the patient's home community.

B. THE RIGHT OF APPEAL

The North Carolina statutes provide 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. §122-58.9.

Appeals from commitment orders are rare in Winston-Salem for two reasons: (1) appointed counsel consider their responsibilities to respondent essentially to cease at the conclusion of the commitment hearing, and (2) appeals usually are not heard until approximately 6-8 months after they are filed, by which time respondent can expect to have been discharged.

C. 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 they are admitted, to select and manage their treatment programs. 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.

Statutes in North Carolina guarantee patients the right to treatment regardless of age or degree of mental illness or retardation. §122-55.5. Statutes also provide a right to be free from unnecessary or excessive medication with drugs and prohibit the use of medication as punishment or discipline. §122-55.6. 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. §122-55.6.

All of the mental health facilities serving Winston-Salem reportedly provide some form of treatment, usually including medication, for all of their committed patients. For a discussion of the ways in which these facilities deal with patients who refuse treatment, see, PREHEARING TREATMENT, in the Prehearing section of this report.

The law in North Carolina does not require mental health facilities to provide periodic progress reports to the committing court, and the facilities serving Winston-Salem do not provide such reports.

The North Carolina statutes provide 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 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." §122-81.2(c). The statutes require 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. §122-55.6.

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 (the local facilities consider themselves short-term facilities), and (3) when the hospital bills for a patient at a private facility no longer are paid (the private facilities reportedly will retain a patient at no charge for a limited period of time before either discharging or transferring the patient). Transfers usually are to the John Umstead Hospital in Butner.

Although some people in Winston-Salem do not know exactly how they are supposed to initiate a transfer, everyone agrees that the assistant clerk of the superior court "takes care of the details" and ensures that the transfer is accomplished in conformity with the law. Reportedly, transfer petitions routinely are granted. No one in Winston-Salem could recall a case in which a patient challenged a transfer. Indeed, no one seemed quite sure 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." §122-58.1. The statutes 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. §122-58.13. 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. §122-58.13.

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. This almost always occurs before the expiration of the 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 (i.e., patients are released if they are 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 a conditional release. Personnel at the John Umstead Hospital recommend that the conditional release procedure be used 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 terribly scarce and that many more are needed in the community.

D. PATIENTS' RIGHTS

As indicated above, the law provides that patients have a right to treatment, a right to be free from unnecessary or excessive medication with drugs, and a right to refuse electro-shock, experimental drugs or procedures, and surgery. In addition, the law in North Carolina recognizes the patient's basic human rights, including the rights to dignity, privacy, and human care and the right to live as normally as possible while receiving care and treatment. §122-55.1. A number of specific rights are enumerated in §122-55.2. These include the right to send and receive mail, make and receive confidential telephone calls, keep and use personal clothing, and exercise all civil rights, including the right to dispose of property, execute instruments, make purchases, enter into contractual relationships, register and vote, and marry and divorce, if not adjudicated incompetent. No one in Winston-Salem suggested to this research staff that any of these rights were denied to involuntary patients at the local facilities or at the John Umstead Hospital in Butner. Our observations at these facilities, although quite limited and brief, were consistent with this.

As was discussed earlier in this report, in the Counsel section, counsel assigned to represent an indigent respondent at the initial court hearing ordinarily remains statutorily responsible for respondent's representation until respondent is unconditionally discharged, if commitment was to a community mental health facility. Respondents committed to the John Umstead Hospital 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.

Despite the requirement that they remain responsible for representing respondents committed to community facilities, 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 ombudsperson, who is responsible for investigating patients' grievances. This ombudsperson

spends approximately one-third of her time doing ombudsperson work; the balance is spent doing public relations work for the hospital. The John Umstead 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. She 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.

E. REHEARINGS

The North Carolina statutes provide that the initial commitment period may not exceed ninety days. §122-58.8. Inpatient commitment may be extended by a rehearing procedure, but outpatient commitment may not be extended. §122-58.11(F).

The rehearing procedure, prescribed by §122-58.11, is as follows. Fifteen days before the end of the initial treatment period, if the chief of medical services of an in-patient facility determines that treatment of an involuntary patient beyond the initial period will be necessary, he or she may notify the clerk of the superior court of the county in which the facility is located. At least ten days before the end of the initial period, the clerk schedules a rehearing and notifies 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. (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 in the Hall of Justice.) 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 in excess of 180 days.

With regard to further rehearings, the statutes (§122-58.11) provide as follows. 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, and, 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 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. §122-58.11(e).

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

## Strengths, Weaknesses, and Recommendations for Improvement

### A. NOTIFICATION REQUIREMENTS

The notification requirements imposed by statute in North Carolina seem to be reasonable. However, the absence of any requirement that notification of respondent's commitment to or discharge from a treatment facility be given to respondent's next of kin, guardian, or other relatives, or that the hospital or the court refrain from notifying particular individuals whom respondent indicates he or she does not want notified, suggests avenues for possible improvement. Because petitioners in Winston-Salem usually are members of the respondent's family, the question of notification might be considered less pressing as a practical matter; however, if only for those cases in which family members are not involved, the development of a notifications policy is advisable. Whether respondent should be permitted to prevent notification of particular persons is a difficult question, particularly if respondent's competence to make such decisions is questionable. However, most people in Winston-Salem seem to agree that respondent's wishes in this regard should be respected.

RECOMMENDATION: IT SHOULD BE THE RESPONSIBILITY OF STAFF OF THE FACILITY IN WHICH RESPONDENT IS COMMITTED TO INFORM RESPONDENT OF HIS OR HER RIGHT TO HAVE FAMILY MEMBERS AND OTHERS (WITHIN REASON) NOTIFIED OF THE COMMITMENT AND OF ANY SUBSEQUENT DISCHARGE. STAFF SHOULD EXPLAIN TO RESPONDENT THAT UNLESS HE OR SHE OBJECTS, THE NEXT OF KIN OR GUARDIAN WILL RECEIVE SUCH NOTIFICATION. IF 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.

### B. 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, perhaps more importantly, 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--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, RESPONDENT'S COUNSEL SHOULD EXPLAIN TO RESPONDENT HIS OR HER RIGHT TO APPEAL AND SHOULD BE AVAILABLE TO PURSUE AN APPEAL FOR RESPONDENT IF 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 RESPONDENT'S BEHALF AND SHOULD NOTIFY THE LOCAL BAR OF THIS POLICY. THE COURT OF APPEALS SHOULD MAINTAIN AN EXPEDITED CALENDAR FOR COMMITMENT APPEALS, WHICH WOULD ALLOW SUCH APPEALS TO BE HEARD WITHIN FIFTEEN DAYS OF FILING.

C. INSTITUTIONAL ACTIVITIES

The statutes in North Carolina regulating the institution's treatment of committed persons seem basically sound. The specification of a right to treatment serves to guard against the sort of 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; research in other cities and our review of the professional literature indicate that the use of medication is a popular, but highly inappropriate, patient management device. The lack of a provision in the law or a consistent policy in the local facilities with regard to whether and to what extent committed persons have a right to refuse treatment is a weakness in the commitment system, however. For a discussion of this issue, see, PREHEARING TREATMENT, in the Prehearing section.

People in Winston-Salem indicate that any requirement that treatment facilities provide committing courts with periodic reports concerning the progress of committed persons would be meaningless. Indeed, given that the court does not participate in treatment or release decisions, the information provided in progress reports probably would serve no useful purpose. Moreover, the time spent preparing and submitting such reports would reduce the availability of facility personnel to treat patients.

No one in Winston-Salem seems terribly unhappy with the procedures used to transfer involuntary patients from one facility to another. Because, however, the transfer process might be (and, in fact, usually is) used 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 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 48 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 48-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 AND SHOULD NOTIFY THE LOCAL BAR OF THIS POLICY.

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 society. 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.

It is a strength of the commitment system in Winston-Salem that the facilities make an effort to refer patients upon release to community programs offering services from which they can benefit. 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.

D. PATIENTS' RIGHTS

The law in North Carolina provides in great detail for the protection of the human rights of committed persons. Given that mental institutions through the years have acquired poor reputations in this regard, the thorough statutory concern for patients' rights in North Carolina is praiseworthy. The impressions of this research staff, developed during visits to institutions serving Winston-Salem, are that these facilities protect the rights of patients to an unusual degree. Meaningful programs of treatment seem to be available, and living conditions seem relatively pleasant.

The statutory recognition of an involuntary 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 sometimes require the assistance of an attorney--marriage, divorce, bankruptcy, etc.--do not cease during commitment; rather, a host of new legal problems typically arise. 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 in excellent compliance with statute. 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. On the other hand, the failure of appointed counsel in Winston-Salem to provide continuing representation for persons committed to the local facilities seems to be in violation of statute and may seriously diminish the patient's ability to protect his or her legal interests. The employment of a part-time ombudsperson at the Mandala Center is to be commended, but it should not be regarded as a satisfactory substitution for the provision of legal assistance.

RECOMMENDATION: UNLESS A SYSTEM IS DEVELOPED IN WINSTON-SALEM WHEREBY A SPECIAL COUNSEL IS DESIGNATED TO BE RESPONSIBLE FOR REPRESENTING RESPONDENT'S INTERESTS DURING THE PERIOD OF COMMITMENT, COUNSEL ASSIGNED TO REPRESENT RESPONDENT AT THE INITIAL HEARING SHOULD BE REQUIRED TO REMAIN RESPONSIBLE FOR RESPONDENT'S REPRESENTATION DURING THE COMMITMENT PERIOD (AS REQUIRED BY LAW). IN ORDER FOR SUCH POST-COMMITMENT REPRESENTATION TO BE EFFECTIVE, COUNSEL SHOULD BE REQUIRED TO HAVE CONTACT BY MAIL, BY TELEPHONE, OR IN PERSON, WITH RESPONDENT OR OTHERWISE BE AVAILABLE AT THE FACILITY IN WHICH RESPONDENT IS DETAINED AT LEAST MONTHLY DURING THE PERIOD OF COMMITMENT.

E. REHEARINGS

Generally, the rehearing procedures prescribed by statute in North Carolina seem quite good. Because rehearings are relatively rare, this research staff received little information about how the procedures work in practice. The only problem voiced in Winston-Salem was that the statutory prohibition of rehearings for persons ordered into outpatient treatment makes no sense. At first blush, we tend to agree; however, with so little information about this matter, further comment would seem inappropriate.

# Appendix A

## Commitment Forms Used in Winston-Salem

STATE OF NORTH CAROLINA

County of _____

File #_____
Film #_____
In the General Court of Justice
District Court Division

In the Matter of

_____

_____

_____
Name and Address of Respondent

PETITION FOR INVOLUNTARY COMMITMENT

The undersigned petitioner, _____, having sufficient knowledge to believe that the respondent is a proper subject for involuntary commitment, alleges:

1.

That the respondent is a resident of or can be found in the above named county.

2.

That the respondent is:

( ) a mentally ill or inebriate person who is dangerous to himself or others.

( ) a mentally retarded person who, because of an accompanying behavior disorder, is dangerous to others.

The facts upon which this opinion is based are as follows:

_____

_____

_____

_____.

3.

The name, address and telephone number of the respondent's nearest known relative or guardian are as follows:

4.

The names, addresses and telephone numbers of other persons who may be able to testify as to the facts supporting this petition are as follows:

Petitioner prays the court to hear this matter and to issue an order to a law enforcement officer to take the respondent into custody for the purpose of determining if the respondent should be involuntarily committed.

Sworn to and subscribed before me this

_____ day of _____, 19____.

_____
Magistrate/Deputy/Assistant
Clerk of Superior Court/Notary Public

My Commission Expires: _____

(Seal)

_____
Petitioner

_____
Relationship to Respondent

_____
Address

_____
County

_____
Telephone Number

NOTE: A qualified physician who is a petitioner may appear before a notary public, magistrate, deputy clerk, assistant clerk, or clerk of the superior court. All other petitioners must execute this petition before any of the above except a notary public.

* * * * * * * * * * * * * * * * * * * * * * *

PETITIONER'S WAIVER OF NOTICE OF HEARING

I do hereby voluntarily waive my right to notice of all hearings and rehearings in which the court may commit the respondent, or extend the respondent's commitment period, or discharge the respondent from the treatment facility.

This the _____ day of _____, 19____.

_____
Witness

_____
Signature of Petitioner

* * * * * * * * * * * * * * * * * * * * * * *

ADDITIONAL OATH REQUIRED OF LAW ENFORCEMENT OFFICER
IN EMERGENCY PROCEEDING

The undersigned law enforcement officer, having sworn to and subscribed to the petition which appears above, further alleges:

That I have taken the respondent into custody and brought him immediately before the court because he is violent and requires restraint and the delay which would result from obtaining a medical examination would endanger life or property.

Petitioner prays the court to hear this matter and to authorize the transportation of the respondent to a treatment facility for temporary custody, observation and treatment pending a district court hearing.

Sworn to and subscribed before me this

_____ day of _____, 19____.

_____
Magistrate/Deputy/Assistant
Clerk of Superior Court

_____
Law Enforcement Officer

_____
Address or Rank and Department

STATE OF NORTH CAROLINA

County of _____

File #_____
Film #_____
In the General Court of Justice
District Court Division

In the Matter of

_____

_____

_____
Name and Address of Respondent

CUSTODY ORDER

INVOLUNTARY COMMITMENT

(Requiring Preliminary Examination by Physician)

To any Sheriff, Deputy Sheriff, Police Officer or Highway Patrolman:

This cause coming on to be heard and being heard before the undersigned upon the petition of _____, the court concludes as follows:

( ) That there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent is probably mentally ill or inebriate and dangerous to himself or others.

It is, therefore, ORDERED that you take the respondent into custody for examination by a qualified physician according to the terms of G.S. § 122.58.4(a).

If the physician finds that the respondent is not mentally ill or an inebriate, or is not dangerous to himself or others, then you shall release the respondent.

If the physician finds that the respondent is mentally ill or an inebriate, and is dangerous to himself or others, then you or some other appropriate law enforcement officer shall transport the respondent to _____ for temporary custody, examination, and treatment pending a district court hearing.

( ) That there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent is probably mentally retarded and, because of an accompanying behavior disorder, is dangerous to others.

It is, therefore, ORDERED that you take the respondent into custody for examination by a qualified physician according to the terms of G.S. § 122.58.4(a).

If the physician finds that the respondent is not mentally retarded or lacks a behavior disorder which would cause the individual to be dangerous to others, then you shall release the respondent.

If the physician finds that the respondent is mentally retarded and, because of an accompanying behavior disorder, is dangerous to others, then you or some other appropriate law enforcement officer shall transport the respondent to _____ for temporary custody, examination, and treatment pending a district court hearing.

Issued at _____ o'clock __.m., this _____ day of _____, 19_____.

_____
Telephone Number of Issuing Official

_____
Magistrate/Deputy/Assistant Clerk of Superior Court

G.S. 122.58.3, - 58.4(b)
AOC-L Form 401
Rev. 8-79

(OVER)

## OFFICER'S RETURN

1. This custody order was received on the _____ day of _____, 19____.
2. ( ) Though diligently sought, as of the _____ day of _____, 19____, the respondent could not be found in this county. He is believed to be _____ _____.

   ( ) The respondent was taken into custody at _____ o'clock __.m., the _____ day of _____, 19_____.
3. Because a physician was not immediately available, the respondent was temporarily detained at the following place:_____ _____.
4. The respondent was presented to a qualified physician for examination at _____ o'clock __.m., the _____ day of _____, 19_____.
5. ( ) The examining physician, _____, M.D., found that the respondent is not mentally ill or an inebriate or mentally retarded or is not dangerous to himself or others. I, therefore, RELEASED the respondent from custody. ( ) The written statement of the physician is attached. ( ) The physician will forward his written statement to the clerk.

   ( ) The examining physician, _____, M.D., found that ( ) respondent is mentally ill or an inebriate and is dangerous to himself or others. ( ) the respondent is mentally retarded and, because of an accompanying behavior disorder, is dangerous to others. I, therefore, placed the respondent in the custody of the following facility:_____ _____ at _____ o'clock __.m., on the _____ day of _____, 19_____. ( ) The written statement of the physician is attached. ( ) The physician will forward his written statement to the clerk.

_____
Law Enforcement Officer

_____
Address or Rank and Department

STATE OF NORTH CAROLINA

County of _____

File # _____

Film # _____

In The General Court of Justice
District Court Division

In The Matter Of

_____

_____

_____

Name and Address of Respondent

CUSTODY ORDER
INVOLUNTARY COMMITMENT

FOR SPECIAL EMERGENCY USE ONLY OR
WHEN THE AFFIANT IS A PHYSICIAN --
NOT REQUIRING PRELIMINARY EXAMINATION

To any Sheriff, Deputy Sheriff, Police Officer or Highway Patrolman:

This cause coming on to be heard and being heard before the undersigned upon the petition of _____, the court finds as follows:

☐ That the affiant who executed the petition is a qualified physician and there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent is ( ) probably mentally ill or inebriate and imminently dangerous to himself or others. ( ) probably mentally retarded and, because of an accompanying behavior disorder, is imminently dangerous to others.

☐ That the affiant who executed the petition is a law enforcement officer who took the respondent into custody pursuant to the special emergency procedures for violent persons and there are reasonable grounds to believe that the facts alleged in the petition are true and that the respondent is ( ) probably mentally ill or inebriate and imminently dangerous to himself or others. ( ) probably mentally retarded and, because of an accompanying behavior disorder, is imminently dangerous to others.

Furthermore, it has been proved by clear, cogent, and convincing evidence that the respondent is in fact violent and requires restraint and that delay in taking the respondent to a qualified physician for an examination would endanger life or property.

It is therefore ordered that you take the respondent into custody or retain him in your custody and that you or some other appropriate law enforcement officer transport the respondent to _____ for temporary custody, examination and treatment pending a district court hearing.

Issued at _____ o'clock ___.m., this _____ day of _____, 19____.

_____
Telephone Number of Issuing Official

_____
Magistrate/Deputy/Assistant
Clerk of Superior Court

G. S. 122-58.3(b); -58.4(b); -58.18
AOC-L Form 403
Rev. 9/77

[OVER]

OFFICER'S RETURN

[1] This custody order was received on the _____ day of _____, 19___.

[2] ☐ Though diligently sought, as of the _____ day of _____, 19___, the respondent could not be found in this county. He is believed to be _____

_____.

☐ The respondent was taken into custody at _____ o'clock ____.m., on the _____ day of _____, 19____.

[3] At _____ o'clock ____.m., on the _____ day of _____, 19___, I placed the respondent in the custody of the following facility: _____

_____.

_____
Law Enforcement Officer

_____
Address or Rank and Department

STATE OF NORTH CAROLINA
County of _____

In the General Court of Justice

In The Matter Of _____
*(respondent)*

TO: _____

_____

_____

AUTHORIZATION TO TRANSPORT
AND DELIVER RESPONDENT

Pursuant to the provisions of North Carolina General Statutes, Section 122-58.14 as amended by Chapter 915, Session Laws of 1979, and upon your request, you are hereby authorized and directed to transport the respondent herein to _____ _____, a mental health facility located at _____, North Carolina, and there to deliver the said respondent to the admitting official in accordance with the orders of the Court.

You will secure from the admitting official an acknowledgment of your delivery of the said respondent and the court records pertaining to his admission, which shall be returned to this Court within 48 hours after such delivery.

This _____ day of _____, 19_____.

_____
Assistant/Deputy/Clerk of Superior Court
Magistrate, District Court Judge

---

ACKNOWLEDGMENT

Receipt of the above respondent and the court records pertaining to his admission, at this mental health facility as of _____ _____m. _____, 19 _____ is acknowledged.

Admitting Official _____

Title _____

_____
(Name of Facility)

G.S. 122-58.14
AOC-L 430
10/79

(Complete in triplicate, original for facility, copies to addressee, respondent's file)

STATE OF NORTH CAROLINA

County of _____

File #_____

Film #_____

In The General Court of Justice
District Court Division

In The Matter of

_____

_____

_____

Name and Address of Respondent

NOTICE OF HEARING
FOR INVOLUNTARY COMMITMENT

To the respondent named above --- GREETING:

TAKE NOTICE that it has been alleged that you are a proper subject for involuntary commitment to a treatment facility pursuant to the laws of the State of North Carolina. You are hereby notified to appear at a hearing before a judge of the district court to be held at _____ o'clock, ___.m., on the _____ day of _____, 19____, at the _____ County Courthouse. You have a right to be represented by an attorney at the hearing and should employ an attorney if you have not already done so. If you are indigent and cannot afford to pay an attorney, you should contact the clerk of superior court of the county named above. The clerk will advise the district court judge who will appoint an attorney to represent you.

At the hearing, evidence will be presented as to your condition and you will be allowed to present evidence. Upon the basis of the evidence presented, the judge will decide whether you should be released, whether you should be committed to a treatment facility for a period not to exceed 90 days or whether you should undergo outpatient treatment at a State or private facility.

Issued at _____ o'clock ____.m., this _____ day of _____, 19____.

_____

Assistant/Clerk of Superior Court

This Notice shall also be served upon the attorney indicated below:

_____ _____

Attorney Address

G.S. 122-65(1)
AOC-L Form 402
9/73

(OVER)

## RETURN OF SERVICE

I certify that this Notice was received on the _____ day of _____, 19____ and was served as follows:

On _____ on the _____ day of _____, 19____

at the following place: _____
(Fill in address where copy was delivered or left)

By: ( ) delivering a copy to him personally. ( ) leaving a copy at this person's dwelling house or usual place of abode with _____ who is a person of suitable age and discretion and who resides therein.

---

On _____ on the _____ day of _____, 19____

at the following place: _____
(Fill in address where copy was delivered or left)

By: ( ) delivering a copy to him personally. ( ) leaving a copy at this person's dwelling house or usual place of abode with _____ who is a person of suitable age and discretion and who resides therein.

If not served on person, state reason and give his name: _____

_____

_____ Sheriff o

_____ County, Nor h Carolina

By _____ Deput

Date _____

## ACCEPTANCE OF SERVICE BY RESPONDENT

This is to acknowledge that I received this Notice on the _____ day of _____, 19_____, at _____ o'clock __.m., and that a copy of the Notice was retained by me.

_____
Respondent

## ACCEPTANCE OF SERVICE BY ATTORNEY

This is to acknowledge that I received this Notice on the _____ day of _____, 19_____, at _____ o'clock __.m., and that a copy of the Notice was retained by me.

_____
Attorney

STATE OF NORTH CAROLINA
County of _____

File # _____
Film # _____

In The General Court of Justice
District Court Division

In The Matter of

_____

_____

_____
Name and Address of Respondent

NOTICE OF HEARING
INVOLUNTARY COMMITMENT
PROCEEDING

To the person named below --- GREETING:

_____
(Name of Petitioner/Parent/Guardian)

_____
(Address)

TAKE NOTICE that, in the above proceeding, a hearing will be held before a judge of the district court at _____ o'clock, ____.m., on the _____ day of _____, 19____, at the _____.

At the hearing, the judge of the district court will hear evidence as to the condition of the respondent from any interested party. Upon the basis of the evidence presented, the judge will determine whether:

☐ the respondent should be committed to a treatment facility for a period not to exceed 90 days or undergo outpatient treatment at a State or private facility;

☐ the respondent should be recommitted to a treatment facility for further care and treatment beyond the respondent's present period of commitment;

☐ the respondent should be committed to a treatment facility for a period not to exceed 90 days upon respondent's failure to adhere to a prescribed outpatient program.

Issued at _____ o'clock, ____.m., on this _____ day of _____, 19____.

_____
(Deputy/Assistant/Clerk of Superior Court)

(NOTE: This NOTICE OF HEARING should be served on the person named above at least 48 hours in advance of the date of hearing set out in the notice.)

G.S. 122-56.7(d);
G.S. 122-58.18A
AOC-L Form 411
6/77

(OVER)

## SHERIFF'S RETURN

I certify that this notice was received on the _____ day of _____, 19_____.

☐ It was personally served on the petitioner on the _____ day of _____, 19_____.

☐ It was not served for the following reasons: _____

_____

_____

This _____ day of _____, 19_____.

_____

Department County Officer

INSTRUCTIONS FOR SERVICE OF INVOLUNTARY COMMITMENT PAPERS

In the Matter of: _____

The respondent can be located at: _____

_____

☐ For information that may be helpful call _____ at telephone number _____ before going after respondent.

☐ A (family member)(friend) will meet you: _____

☐ The respondent will be alone. ☐ Use caution.

☐ I have been advised weapons (are)(are not) available which could be used against you: _____

☐ Other information: _____

☐ I have been advised transportation may be difficult. It may be necessary to use (an ambulance)(a police car having a large rear seat).

After taking this person into custody for examination by physician, deliver t

☐ 4th floor Reynolds Health Center ☐ FMH Emergency Room

☐ 2nd floor Whitaker Care, Psychiatric Unit, at FMH ☐ Mandala Center

If the physician finds the person to be committable, place in:

☐ 4th floor Reynolds Health Center ☐ Mandala Center

☐ 2nd floor Whitaker Care, Psychiatric Unit, at FMH

☐ Custody of Sheriff's Dept. who will transport respondent to the VA Medical Center in Salisbury.

☐ Custody of the Sheriff's Dept. who will transport the respondent to John Umstead Hospital in Butner.

RELEASED BY PHYSICIAN: If the respondent IS NOT involuntarily hospitalized by the physician, execute the original Custody Order and Notice of Hearing to show that respondent was released. Return originals and copies in accordance with instructions in item #6 below.

COMMITTED BY PHYSICIAN: If the respondent IS committed, execute the original Custody Order and Notice of Hearing as is appropriate. Return original papers in accordance with instructions in item #6 below. Leave the copies of the Petition, Custody Order, and Notice of Hearing with the hospital.

PROMPT RETURN OF PAPERS: Return the papers by the quickest means available to Assistant Clerk Larry Councilman.....or.....to the Warrant Issuing Office and marked to the attention of Larry Councilman.

_____

_____

County _____

**QUALIFIED PHYSICIAN EXAMINATION AND EVALUATION**
**TO DETERMINE NECESSITY FOR INVOLUNTARY COMMITMENT**
**TO A FACILITY OF THE N.C. DIVISION OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES**

File # _____
Film # _____

(Pursuant to G.S. 122-58.4 / G.S. 122-58.6)

| NAME OF RESPONDENT: | AGE | BIRTHDATE | SEX | RACE | M.S. |
|---|---|---|---|---|---|
| | | | | | |

ADDRESS (Street, Apt., Route, Box Number, City, State & ZIP)

County

Telephone

NEXT OF KIN/RESPONSIBLE PERSON:

Relationship

ADDRESS:

Telephone

PETITIONER:

Relationship

ADDRESS:

Telephone

I, the undersigned physician, licensed to practice in North Carolina, examined said person on _____, 19___, at___o'clock ___m. in _____ and made the following findings of: ☐ mental illness, ☐ inebriacy, or ☐ mental retardation with a behavior disorder (FINDINGS MUST BE DESCRIBED):

And further, I made the following findings of danger to self or others (FINDINGS MUST BE DESCRIBED):

Abnormal Physical Condition:

Current Medications (medical & psychiatric):

As a result of my examination, it is my opinion that the respondent:

☐ is ☐ is not mentally ill.
☐ is ☐ is not inebriate.
☐ is ☐ is not dangerous to self or others.
☐ is ☐ is not mentally retarded with a behavior disorder and dangerous to others because of the behavior disorder.

Tentative Diagnosis:

_____ M.D.
Qualified Physician - Signature

_____ M.D.
Qualified Physician - Printed

Recommendations for Disposition:

☐ Release (Preliminary Evaluation)
☐ *Release pending District Court Hearing* (Facility)
☐ Involuntarily Hospitalized
☐ Other (specify) _____

_____
Address or Facility

City _____ State _____

Telephone Number _____

**QUALIFIED PHYSICIAN EXAMINATION AND EVALUATION**
**TO DETERMINE NECESSITY FOR INVOLUNTARY COMMITMENT**
**TO A FACILITY OF THE N.C. DIVISION OF MENTAL HEALTH, MENTAL RETARDATION**
**AND SUBSTANCE ABUSE SERVICES**

(Pursuant to G.S. 122-58.4 / G.S. 122-58.6)

**NOTE: This is a legal document which will be placed in a court file to which there is public access. In addition, the respondent may be released by the court if this form is not completed accurately.**

**EXAMINATION:** Specific description of **your** findings based on **your** examination of the respondent may be used as evidence in judicial proceedings. (History of prior mental hospitalizations cannot be used as sole evidence for involuntary commitment.)

**DISPOSITION:** Release may be recommended by the initial qualified physician when requirements for involuntary commitment are not met.

Release pending district court hearing may be recommended by the facility qualified physician when requirements for involuntary commitment are not met.

Outpatient commitment to the mental health center after a period of inpatient stabilization may be recommended by specification following the block marked "Other."

**STATUTORY DEFINITIONS:**

The words "mental illness" shall mean: (1) when applied to an adult, an illness which so lessens the capacity of the person to use 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. The words "mentally ill" small mean an adult person with a mental illness; or (2) when applied to a minor shall mean a mental condition, other than mental retardation alone, which so lessens or impairs the youth's capacity either to develop or exercise age appropriate or age adequate self-control, judgment, or initiative in the conduct of his activities and social relationships as to make it necessary or advisable for him to be under treatment, care, supervision, guidance or control. G.S. 122-36(d).

The word "inebriate" shall mean a person 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. G.S. 122-36(c).

The words "mentally retarded" shall mean a person who is not mentally ill but whose mental development is so retarded that he has not acquired enough self-control, judgment and discretion to manage himself and his affairs, and for whose own welfare or that of others, supervision, guidance, care or control is necessary or advisable. G.S. 122-36(e).

"Behavior disorder" when used in this Article shall mean a pattern of maladaptive behavior that is recognizable by adolescence or earlier and is characterized by gross outbursts of rage of physical aggression against other persons or property. G.S. 122-58.2 (4).

**COPIES:** Evaluation prior to admission to treatment facility—original and 3 copies to law enforcement officer. NOTE: If it cannot be reasonably anticipated that the clerk will receive the copies within 48 hours of the time that it was signed, the physician shall also communicate his findings to the clerk by telephone G.S. 122-58.4(d).

Evaluation in treatment facility:
Original—Clerk of Superior Court of sending county;
Copy—Clerk of Court of county in which facility is located;
Copy—Medical record;
Copy—Special Counsel;

Other copies that may be specified.

STATE OF NORTH CAROLINA

County of _____

File #_____

Film #_____

In The Matter Of

_____

_____

_____

Name and Address of Respondent

In The General Court of Justice
District Court Division

INFORMATION CONCERNING
APPOINTMENT OF COUNSEL

The undersigned has been informed of the respondent's right to be represented by an attorney at the hearing before the district judge to determine if the respondent should be involuntarily committed to a treatment facility. The undersigned represents as follows:

☐ That an attorney has already been employed to represent the respondent at the hearing and his name, address and telephone number is as follows:

☐ That the respondent, family member or guardian is financially able to employ an attorney and that an attorney will be employed prior to the time of the hearing.

☐ That the respondent, family member or guardian is financially able to employ an attorney, but it is requested that the court select and appoint an attorney prior to the time of the hearing.

☐ That the respondent is indigent and cannot afford to pay an attorney, and it is requested that the court select and appoint an attorney prior to the time of the hearing.

This the _____ day of _____, 19____.

_____
Respondent

(Relationship)_____

(Address)_____

(Telephone No.)_____

_____
Family Member

(Address)_____

(Telephone No.)_____

_____
Guardian

Signed in the presence of _____
Magistrate/Assistant/Deputy Clerk of Superior Court

G.S., 7A-451; 122-58.3
AOC-L Form 408
12-78

*NOTE:* This form is sufficient if signed by the respondent alone, the family member alone, or the guardian alone. However, it is recommended that the form be signed by each of the parties who are present.

STATE OF NORTH CAROLINA

County of Forsyth

IN THE GENERAL COURT OF JUSTICE
DISTRICT COURT DIVISION

File Number ___SP_____

_____

Respondent

ORDER OF ASSIGNMENT OF COUNSEL

The above-named person, being a party to a proceeding or action listed in GS 7A-451 and/or GS 122-58.7 and there having been made an initial determination of the respondent's indigency and entitlement to representation, and it appearing to the undersigned Judge from the affirmations as appears in the record or after due inquiry made, that said respondent is financially unable to provide the necessary expenses of legal representation or that the respondent, family member or guardian is financially able to employ an attorney, but has refused to do so; it is, therefore, ORDERED AND ADJUDGED that the respondent is an indigent or has refused to employ counsel and is entitled to the services of counsel as contemplated by law; and that _____, Attorney at Law, is hereby assigned as counsel for the respondent as provided in Chapters 7A and 122 of the General Statutes.

This the _____ day of _____, 19____.

_____

District Court Judge

STATE OF NORTH CAROLINA

County of _____

File #_____

Film #_____

In The Matter of

In The General Court of Justice
District Court Division

_____

_____

_____

Name and Address of Respondent

FINANCIAL STATUS QUESTIONNAIRE

The following answers to the questions hereunder are true to the best of my knowledge and belief:

1. By whom is respondent employed? _____

_____

2. What is his (her) present income, if any? _____

3. If not employed, reason. _____

_____

4. Does respondent have any cash? _____

5. Does anyone owe respondent any money? If so, state who and what amount.

_____

_____

6. What is spouse's income? _____

7. What make and model automobile, if any, does respondent own?

_____

8. List all other personal property belonging to respondent, such as stocks, savings accounts and bonds, etc.

_____ Value _____

_____ _____

_____ _____

9. List all real property and location owned jointly or separately by the respondent.

_____

_____

_____

10. Total indebtedness. _____

G.S. 35-45; 108-106.2(b);
& 122-58.3(c)
AOC-L Form 409
Rev. 4/76

[OVER]

CERTIFICATE OF INDIGENCY

I hereby certify that the answers to the questions on the reverse side of this form are true to the best of my knowledge and belief and that the respondent is indigent and cannot afford to pay an attorney to represent him in this proceeding.

This _____ day of _____, 19____.

_____
Respondent

(Relationship)_____

(Address)_____

(Telephone No.)_____

_____
Family Member

(Address)_____

(Telephone No.)_____

_____
Guardian

Signed in the presence of _____
Magistrate/Assistant/Deputy Clerk of Superior Court

*NOTE:* This form is sufficient if signed by the respondent alone, the family member alone, or the guardian alone. It is recommended, however, that the form be signed by each of the parties who are present.

# Appendix B

## Data Collection Instruments

Part 1. Interview Guide

Part 2. Observation Guide

# PART 1. INTERVIEW GUIDE

## INVOLUNTARY CIVIL COMMITMENT PROJECT

## DATA COLLECTION GUIDE

### PURPOSE

The ultimate goal for this research project is to generate information by which the civil commitment process can be made to function as well as possible. The purpose of this data collection is to obtain practitioners' opinions, advice, and suggestions about the civil commitment process, particularly about the process as it operates in their own localities. Our staff has become familiar with each state's statute and basic commitment process. We know, however, that systems do not always operate exactly as statutes prescribe. Situations occasionally arise that are not explicitly provided for in statute. People who work with a system on a day-to-day basis can explain why things are done as they are and can offer insights into how a system might be made to operate most smoothly.

This research is entirely qualitative, not quantitative. Our main purpose is not to ask how many, or even how. Our purpose is to ask why, how well, and how else. Assuming that we are aware of the basic statutes and procedures, questions do not call for descriptions of legal requirements or commitment process events, per se. Descriptions of law and process are requested only to help explain advantages, disadvantages, and possible modifications of a system. We seek information about what works best and why.

### APPROACH

This is not a typical research survey. The people with whom we are speaking have been chosen because they are well informed about the civil commitment process. Thus, our sample of interviewees is not a statistically representative sample; we therefore have no reason to count what percent of interviewees feel one way or the other. Our job in this research is to report on the unique and authoritative insights that these key people can impart. Because we are looking for what works best, the research has not been designed to show validly what is average or typical.

The questions in this data collection guide are open-ended. Multiple choice types of questions have been avoided so that interviewees will be free to formulate their own opinions rather than having their thoughts slotted into predetermined categories by the researchers. The only exceptions to this are the few background questions about each interviewee. Using these questions, we hope to group the interviewees into a small number of predetermined categories to help us understand how different types of people view different issues.

ORGANIZATON

This data collection guide is a complete set of all the questions that are to be investigated. People will be interviewed individually and in homogeneous groups. Some of the questions also will be answered by project staff on the basis of their own empirical observations. Project staff have a separate observation guide to help them note important events and to key the observation information to appropriate questions in this data guide.

The interview covers many topics. The complete data collection flows in a more-or-less chronolgical order, as events occur during a typical commitment process. The questions unavoidably overlap each other to some degree, but repitition was minimized as much as possible.

All the questions are coded according to the types of people whom we expect will be able to give us the desired information. The codes and their meanings are these:

| | |
|---|---|
| J | Judges, magistrates, special justices, and so on; |
| C | Clerks and other court personnel; |
| L | Law enforcement officers, probation officers, and so on; |
| A | Attorneys and patients' rights advocates; |
| P | Psychiatrists, psychologists, social workers, and so on; |
| R | Respondent, petitioner, family members and other lay individuals; |
| O | Direct observation. |

Because of the length of the data collection guide, every question will not be asked of every interviewee. We will select a subset of questions to present in each interview, trying to optimize the match of peoples' areas of knowledge with the questions asked. Everyone will be invited, however, to discuss any aspect of the commitment process with which they are familiar or about which they have particular opinions or suggestions.

ADMINISTRATION

Whenever possible, the data collection guide will be sent to interviewees prior to the actual interview. This will give people a chance to consider the issues that are to be raised, collect their thoughts, and prepare their answers in advance, if they wish.

Questions in the data collection guide are in normal type. Text printed entirely in capitals, LIKE THIS, is meant as instruction to interviewers.

Remember that this is only a data collection guide, not a dictum. Precise language in the questions is not important, and neither is the order in which questions are covered. The guide is simply a reminder to important issues and ideas that need to be discussed. More concern is to be given to understanding the answers than to writing them down thoroughly or verbatim. Immediately following an interview, interviewers will go back through their notes to write answers fully and in proper sentences and to be sure that there are no "loose ends." If necessary, telephone calls will be made to review particular comments or to check the exact meaning of unclear answers.

In this vein, the data guide is written is conversational style. We expect the interviews to be conducted as free-flowing discussions. The information will be condensed and cast into the "King's English" during the analysis phase.

Finally, we do not necessarily expect answers to every question that is asked. We recognize that people have concerns and expertise in some areas and not in others. If interviewees do not wish to answer a particular question, the question can be skipped and the interview can progress to the next topic.

## CONFIDENTIALITY

A complete statement regarding confidentiality accompanies each data collection form and is to be reviewed prior to every interview. The most important point of that statement is repeated briefly here. That is, responses to this data collection effort (or staff observations) never will be reported with reference by name to any particular individual. Anonymity of private individuals will be maintained absolutely. The anonymity of public officials will be maintained to the extent that is possible; it is acknowledged that because of their positions and special information, it may not always be possible to present information reported by public officials in a manner that would make it impossible for knowledgeable people to determine that these officials were the source of the information.

INVOLUNTARY CIVIL COMMITMENT PROJECT

Statement of Confidentiality and Project Ethics
August 28, 1981

## Protecting Confidentiality

The reports that result from the information collected by interviews and observations will not identify individuals by name. Any information that reasonably could be expected to identify a private person will be deleted or disguised.

A list of public persons interviewed and the organization each represented will be included in the final report. In the report, where it is appropriate or necessary to identify comments or suggestions with an organization or person, generic descriptions will be used -- e.g., out-patient treatment personnel, attorneys, advocates, in-patient treatment personnel.

It is possible that persons knowledgeable about the mental health or legal communities could identify organizations and public persons representing them as sources of certain reported statements. We will make every reasonable effort to use multiple sources of information in order to reduce the probability of revealing the identity of particular public persons.

Information in our files will generally be deidentified. Personal identifiers will be attached to file materials only when necessary for some valid and important research purpose. We will keep all personally identifiable information in locked file cabinets. All remaining personal identifiers will be deleted or the papers destroyed at the conclusion of the project. Any requests for information that might identify an individual will be refused, unless needed for a valid and important research purpose, and then will be transmitted only after completion of a formal, written information transfer agreement, which will bind the receiver of the information, at the least, to the principles of this Statement of Confidentiality and Project Ethics.

To summarize, we will ensure the complete anonymity of private persons (patients, ex-patients, and families of same). The confidentiality of public persons and institutions will be protected to the maximum extent possible.

## Research Ethics

Our staff is guided by three principles of ethical obligations:

1. We are obliged to participants in protecting their privacy and accruately representing their responses;

2. We have a duty to society, in that we do not waste funds on unnecessary research and that we make public our findings and recommendations; and

3. We are obligated to science and future researchers in conducting reliable and valid research, and documenting our methods and findings.

Informed Consent

Prior to beginning any interview or observing any non-public event for purposes of this research, one of the following statements will be read. Data collection will not occur without the expressed consent of all interview and observation subjects of this research (or of their guardians or responsible spokespersons).

This statement will be read prior to beginning any interview.

> We are from the National Center for State Courts. We are performing a project to help judges and mental health professionals understand and improve the process of ordering involuntary treatment for the mentally ill. We would like to ask you some questions. We greatly appreciate your help with this project. But, please understand that you may refuse to answer any questions that you wish and you may decide to stop this interview at any time. Also, you may interrupt us to ask about the project at any time, and we will answer your questions as fully as we can. Our project is being done according to a written statement of confidentiality and ethics. Your interview statments will be kept entirely confidential (FOR A PUBLIC OFFICIAL ADD: to the best of our ability). Copies of information about this project and of our statement of confidentiality and ethics are available for you to read if you wish. Do you have any questions to ask before we begin the interview?

Prior to observing hearing or prehearing activities, the following statement will be read to the senior court official in the jurisdiction. If he or she so directs, it will be read to any other persons as necessary or appropriate.

> We are from the National Center for State Courts. We are performing a project to help judges and mental health professionals understand and improve the process of ordering involuntary treatment for the mentally ill. We would like the court's permission to observe hearings and other prehearing

events. We will do this with the understanding that anonymity of persons will be maintained according to the project's statement of confidentiality and ethics. At any such time as any subjects of our observations object to our presence, we agree to stop such observations immediately unless we receive your specific permission to contiue them. Copies of information about the project and of the statement of confidentiality and ethics will be available for you and any other persons to read at any time. We also will read this statment to all other persons whom you shall designate, if any. We greatly appreciate your help with this project. But, please understand that you may stop our observations at any time. Also, you and any other persons may ask questions about the project at any time, and we will answer your questions as fully as we can. Do you have any questions before we begin our observations?

Prior to any observations in or at a treatment facility, the following statement will be read to the facility director or other person with authority to consent to our project activites. If he or she so directs, it will be read to any other persons as necessary and appropriate.

We are from the National Center for State Courts. We are performing a project to help judges and mental health professionals understand and improve the process of ordering treatment for the mentally ill. We would like your permission to observe this facility and any examinations or treatment activities that are occurring, which are relevant to our work. We will do this with the understanding that anonymity of persons will be maintained according to the project's statement of confidentiality and ethics. At any such time as any subjects of our observations object to our presence, we agree to stop such observations immediately unless we receive your specific permission to contiue them. Copies of information about the project and of the statement of confidentiality and ethics will be available for you and any other persons to read at any time. We also will read this statment to all other persons whom you shall designate, if any. We greatly appreciate your help with this project. But, please understand that you may stop our observations at any time. Also, you and any other persons may ask questions about the project at any time, and we will answer your questions as fully as we can. Do you have any questions before we begin our observations?

Involuntary Civil Commitment
Master Data Guide

CHECK ONE

_____Interviewer

_____Observer

Date_____ City_____

Place_____

Subject of data collection. FILL APPLICABLE BLANKS

Individual interview:

Name_____

Title or Position_____

Observation:

Re Case_____

Event_____

Group interview: LIST NAME/TITLE OR POSITION

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

PROVIDE THIS INFORMATION FOR ALL SINGLE-PERSON INTERVIEWS. OTHERWISE, SKIP TO PAGE 4.

Before talking with you about specific issues, I would like to get some information about your familiarity with the commitment process and your general feelings about it.

I-1 How many years of experience have you had working in any capacity with the civil commitment of the mentally ill?_____

I-2 How would you describe your familiarity with the civil commitment statutes in this state? READ LIST OF ALTERNATIVES AND CHECK ONE BELOW.

I-3 How would you describe your familiarity with the civil commitment system and procedures in this state? READ LIST AND CHECK ONE

| | I-2 Statutes | I-3 Procedures |
|---|---|---|
| Not at all familiar | _____ | _____ |
| Have partial or slight familiarity | _____ | _____ |
| Know well or know most | _____ | _____ |
| Know thoroughly or are expert | _____ | _____ |

NOW DO THE INTERVIEW, BUT RETURN TO THE FOLLOWING TWO QUESTIONS AT THE VERY END.

For my final few minutes with you, I'm going to ask a couple of questions to help me summarize the way you perceive the civil commitment system in general.

I-4 I am going to read three statements about this state's present civil commitment system. Please indicate which statement you would most closely agree with. READ ALL AND CHECK ONE

_____ This state's system makes it too hard to get a person in for mental health treatment or to protect other people from the dangerous mentally ill.

_____ This state's system makes it too easy to get a person into treatment who may not really need it.

_____ This system strikes a good balance between the interests of committing a person to treatment and protecting the person's wish not to be treated involuntarily.

I-5 Similarly, I am going to read three statements about trends in your state's laws and procedures. Which one most closely reflects your feelings? READ ALL AND CHECK ONE

_____ This system seems to be changing to make it <u>harder</u> to get people committed to treatment.

_____ This system seems to be changing to make it <u>easier</u> to get people committed to treatment.

_____ This system seems to be pretty stable in this regard.

## Prehearing Section

JCL II-1 R — I would like to begin by discussing the way commitment proceedings get started. Considering the people who can initiate the process, the actions they must take to bring their complaint to the attention of the authorities, and any prepetition screening that is done...

a. What do you think are the advantages of this system?

b. What are the disadvantages?

c. What changes would you suggest, and why?

JC A O II-2 a. Do petitions and certifications usually contain all the information required in them by statute?

b. IF NO: Why not? What is lacking?

c. ALL: What other information ought to be provided, and why?

J AP O II-3 — As we understand the statute in your state, in order to initiate commitment, it is necessary to assert that respondent is mentally ill, _____ and/or _____.

a. Is this correct?

b. What else is required?

c. Are these requirements typically met in initiating commitments?

d. IF NOT: Why not?

J AP II-4 a. In your opinion, how should these requirements be altered?

JCL APR II-5 — In some places, people have worked out ways to get help for respondents before any formal hearing takes place. This can be a method for getting help without a formal commitment to treatment, or a way of avoiding the need to take the case through a formal hearing.

a. Are there any ways to do this type of prehearing diversion here?

b. IF YES: What are they, and how well do they work?

c. ALL: Can you suggest some prehearing diversions or screening procedures that are not used here now, but could be?

J L II-6 AP a. Once a commitment process is begun, what circumstances or conditions must exist to justify taking a respondent into custody?

b. What changes, if any, would you suggest in this regard, and why?

J L II-7 A a. Is there any way to avoid holding a respondent in custody prior to an examination or prior to a hearing?

b. IF NO: Is there any reason why this can't be done?

c. IF YES: How and when does this occur?

J L II-8 AP a. How, exactly, is a respondent picked up or taken into custody when a commitment is initiated against him or her?

b. What are the strong points of this process?

c. What are the weak points?

J II-9 AP We know that states differ in their practices with regard to where they hold respondents prior to an examination or hearing. As examples, some states use hospitals or local clinics exclusively, while other states allow people to be held in jails or to remain at liberty in their homes.

a. What facilities are used here to hold respondents most frequently?

b. What are the advantages to using these?

c. What are the disadvantages?

d. What other facilities might be used, and what advantages would they offer?

J II-10 AP a. How long are respondents typically held in custody prior to receiving a hearing? PROBE FOR ANY COMMENTS ON TIME.

J L APR II-11 a. ASK THIS QUESTION ONLY IF ANSWER IS NOT ALREADY OBVIOUS FROM EARLIER QUESTIONS. Do you feel that prehearing detention practices in this system unnecessarily restrict respondent's right to liberty? Why?

b. Do you feel these practices adequately protect society from dangerous mentally ill people? Why?

c. Do you feel these practices are adequate to protect people who might be dangerous to themselves? Why?

d. Do you feel that the prehearing detention practices adequately meet the immediate treatment needs of the hospitalized person?

e. What changes or procedures can you suggest to improve these practices?

J AP II-12 Let's talk a bit about mental health examinations.

a. How many examinations do respondents typically receive prior to a commitment for treatment, and when do they occur?

b. Who does the examinations?

c. What information does an examiner usually have about the respondent prior to the examination?

J APR II-13 a. Does the examination process present any special considerations in this jurisdiction with respect to the examiner and the respondent in their relationships as a doctor and patient?

b. IF YES: How are these considerations dealt with and what are the effects?

c. ALL: Is this a particular problem at time of recertification?

J AP O II-14 a. Do examination reports usually contain all the information required by law?

b. What, if any, information is <u>not</u> contained in examination reports that you think should be included? Why would it be helpful to include this information?

J AP O II-15 a. How frequently does a respondent assert or pursue a right to remain silent during an examination?

b. Is every patient informed of the likely consequences of the examination, and of the right to remain silent, if there is one?

c. IF YES: How and when is this done?

d. ALL: What effect does this have on the examination?

J AP II-16 a. How frequently do respondents request an independent examination?

b. IF EVER: When an independent examination is requested, does it seem to make a significant difference to the proceedings? IF YES: How?

c. IF NEVER: Do you feel that independent examinations should be done? IF YES: Why?

JC A O II-17 The next few questions will be addressed to the matter of respondent's attorney. These questions will be related to the entire commitment process, not just the prehearing stage.

a. Are all respondents represented by counsel?

b. IF NOT: Why are some not represented?

c. ALL: How is indigency determined?

d. What method is used for the appointment of counsel?

e. What qualifications are required for appointed attorneys?

J AP O II-18 a. What do you see as the proper role of counsel for the respondent?

b. Do attorneys tend to advocate strongly for the respondent's liberty interests in all cases, or is this true only when the attorney feels this is in the respondent's best interests?

c. Do you think this should be changed, and why?

JC APR O II-19 a. Do you feel that most attorneys are sufficiently prepared in their roles as counsel for respondent?

b. IF NOT: What more should they be doing?

c. ALL: What kinds of incentives or disincentives exist for counsel to be thorough?

d. ALL: Do you think this should be changed, and why?

JC AP O II-20 a. Do respondents frequently reject the assistance of appointed counsel?

b. IF YES: How is this handled by the court?

c. Are there ways in which this can be handled better?

J AP O II-21 a. How frequently will attorneys challenge an examiner's credentials or conclusions?

b. How frequently will attorneys object to testimony or admissibility of evidence at hearing?

c. Do attorneys ever insist on psychiatrists using lay language?

d. What is the effect whenever any of these actions is done?

JC A II-22 a. Do attorneys have prompt and sufficient access to all information they need for respondent's case?

b. IF NOT: What more do they need, and how can it be provided to them?

c. ALL: Do attorneys make use of all the necessary information relating to the respondent that they have access to?

d. IF NO: What <u>important</u> information might counsel be missing, and what can be done to correct this?

JC AP O II-23 The next questions have to do with prehearing treatment.

a. Under what circumstances, if any, do respondents receive treatment prior to a formal disposition hearing?

b. What types of treatment usually are given?

c. Are respondents ever medicated when they are brought to the hearing? IF YES, ASK: Is this communicated to the court?

d. IF YES: What problems or advantages does this create?

e. ALL: What changes would you suggest?

J AP II-24 a. Do respondents ever assert a right to refuse treatment prior to disposition?

b. IF YES: What happens when respondent does so?

c. ALL: What changes would you suggest in your system with regard to respondent's right to refuse prehearing treatment and why?

JC AP II-25 a. Under what circumstances might a case be dismissed or a respondent be discharged prior to a hearing?

b. If a respondent is discharged from the custody of a mental health facility prior to a hearing, is the case automatically dismissed, or might a hearing be held anyway?

c. Do you feel that a hearing should be held, even after a person has been discharged by a mental health facility?

d. IF YES: Why and in what manner?

JCL APR O II-26 a. When and how is respondent notified of his or her rights, such as the right to counsel, to an independent examination, and to see copies of the petition and certification?

b. What more should be done, if anything, to inform respondents of their rights?

c. Are there formal procedures for waiver of rights?

CL II-27 AP a. Who is notified when a respondent is first taken into custody?

b. What notifications are made if respondent is discharged or the case is dismissed?

c. What procedure is used for giving notices?

d. What other notifications ought to be made?

e. Are notifications given that are unnecessary?

f. What are your practices if a respondent requests that certain people not be notified?

JC II-28 AP a. We are interested in the payment of the costs of prehearing procedures. Could you tell me who is responsible for these costs, who usually pays them, and whether the regulations regarding payment have any important effects on the way the following are done:

1. Picking up the respondent
2. Detention
3. Examination
4. Treatment
5. Emergency hearings

b. Who is responsible for administration and collection of payments?

JCL II-29 APR O Before going on to some questions about the hearing itself, I'd like to find out whether you have any comments to make about the early part of the process, in addition to the things we already have discussed.

a. What aspects of initiating an emergency commitment procedure in your system are especially helpful or problematic, and what comments or recommendations would you make about them?

b. What comments or recommendations would you care to make relating to initiating a commitment by the usual judicial hearing procedure in which no emergency is involved?

c. IF APPROPRIATE TO STATE: Would you care to make any comments about your state's procedures for initiating a commitment that does not require judicial review?

d. What strengths or weaknesses can you comment on regarding your system's ability to use conservatorships or guardianships to get help and treatment for the mentally ill?

e. Do you care to comment on this system's procedures for initiating a commitment proceeding against a person who is currently a voluntary patient and who is seeking release?

f. What particular strengths or weaknesses, if any, does your system have for initiating a commitment for treatment for prisoners?

## The Hearing: Adjudicating Commitment

JC A III-1 a. The questions in this part of the interview will focus on the hearing, per se. But first, let me ask some questions about how treatment might occur without a hearing. Excluding voluntary admission and treatment in emergency situations, is it possible for a person in this system to be committed for treatment without going through a formal hearing?

b. IF YES: How does this happen?

c. ALL: Do you see any reason why this might be advantageous?

d. ALL: Would you suggest any changes in this regard?

JC A III-2 a. Does respondent ever have trouble obtaining a prompt hearing?

b. IF YES: What is the difficulty and how might it be overcome?

c. ALL: What period of time do you feel is needed between the filing of a petition and holding a hearing?

d. ALL: What difficulties would arise in holding the hearing prior to this time?

JC AP O III-3 a. Where are commitment hearings typically held?

b. What are the advantages and disadvantages of holding hearings there?

c. Would you suggest having the hearings somewhere else?

d. IF YES: Under what circumstances, and where?

JC APR O III-4 a. Is the respondent given an opportunity to elect voluntary admission prior to or during a hearing?

b. IF YES: Do you favor giving respondent this opportunity? Why?

c. Before permitting a respondent to choose voluntary admission, does the court consider whether the respondent has the capacity to make treatment decisions?

d. What changes would you suggest, if any, in the process of allowing for election of voluntary admission?

J AP O III-5 a. Our understanding of your civil commitment code is that a person must be found to be _____, _____ _____ and/or _____ in order to support a commitment. Is this correct? Is it interpreted this way in practice?

b. Are these requirements typically met?

c. What other factors appear to influence the court's decision?

d. What specific facts typically are presented to the court to support these criteria and the existence of other factors?

e. What changes do you think are called for in the legal criteria supporting a commitment for treatment?

J APR III-6 a. Does your system have a problem with chronically disturbed people who seem to be regularly in and out of treatment facilities? IF NO, GO TO III-7.

b. IF YES: What exactly are the nature and cause of the problem?

c. Can you suggest a solution?

JC AP O III-7 a. How, if at all, does a consideration of less restrictive alternatives enter into the hearing? That is, how, if at all, does the topic get raised and who presents testimony in this regard?

b. (ASK ONLY IF NOT OBVIOUS FROM LAST ANSWER) Does the court dismiss the case if a less restrictive alternative is identified?

c. ALL: Do you feel that adequate attention is given to less restrictive treatment alternatives in the hearing?

d. IF NOT: What more, specifically, should be done?

JC III-8 a. Do hearings typically include a state's attorney or district attorney?

b. What is the best role for state's attorney in a commitment hearing?

JC A III-9 a. How frequently does a hearing include an attorney for the petitioner?

b. What advantage or disadvantage is there in having petitioner represented by counsel?

JC A III-10a. Under what circumstances are commitment hearings held before a jury?

b. What are your feelings about jury hearings in such cases?

JC AP O III-11a. Is respondent always present at the hearing?

b. IF NO: Under what circumstances would respondent not be there?

c. ALL: What recommendations would you make about holding the hearing without respondent being present?

J O III-12a. How frequently is a person who examined respondent present to testify at a hearing?

b. IF NOT ALWAYS: How is examination evidence presented if the examiner is not present?

c. ALL: What recommendations would you make about having examiners present at hearings?

JC AP O III-13a. In practice, how strongly does the examiner's testimony or evidence influence the court and, in effect, determine the outcome of the hearing?

b. Should this be different?

c. IF YES: What can you suggest to change this?

J AP O III-14a. How frequently do psychiatrists and other examiners present a neutral assessment of respondent's condition, or how frequently do they act as advocates either for or against respondent's commitment?

b. What is the effect of this?

c. How, if at all, should this be changed?

J AP O III-15a. What other witnesses (such as petitioner) typically are at the hearings?

b. How do you feel about the effects or importance of having such witnesses at the hearings? BE SURE TO EXPLORE THIS QUESTION FOR EACH WITNESS MENTIONED IN III-15 a.

J A O III-16a. Who actually conducts the hearings, a judge or somebody else?

b. During a hearing, does the judge [OR OTHER OFFICIAL ACTING IN THIS CAPACITY] typically take an active part in directing questions to respondent and witnesses, or does the judge usually just listen as the case is presented by counsel?

c. Does this seem to be a good way to conduct the hearing? Why?

d. IF ANSWER IS NOT ALREADY OBVIOUS, ASK: What would you recommend as the best role for a judge in a commitment hearing?

JC AP O III-17a. Are hearings typically open or closed to the public?

b. What are the problems or advantages to the way your court system handles this?

JC III-18a. Does the court make a permanent record of commitment hearings? IF YES: How?

b. Is a permanent record useful or necessary? Why?

c. What additional costs are created by making a permanent record, and are the costs justified by the need?

d. What policies would you recommend for retaining or destroying civil commitment records? Why?

e. What policies ought to be followed in sealing the records and in allowing various parties to have access to these records? Why?

J A O III-19a. Under what circumstances are continuances granted?

b. What useful or harmful effects have you noticed as a result of granting continuances?

J A O III-20a. Does the court apply formal rules of procedure and rules of evidence to the commitment hearing?
Procedure_____ Evidence_____

b. What is your opinion about allowing hearsay testimony?

c. What is your feeling about allowing information about previous commitments as evidence?

d. Do you care to comment further about your system's practices regarding procedure, evidence, and testimony?

JC A O III-21 I have some further questions about notification.

a. Who is given notification of commitment hearings and at what time?

b. When, if at all, is respondent notified of the right to elect voluntary admission?

c. When, if at all, is respondent notified of the right to a jury?

d. What recommendations do you have regarding these or other notifications?

JC A III-22a. What provisions are made for paying costs associated with a hearing?

b. Who is responsible?

c. Who usually pays?

d. Do the regulations governing payments have any important effects on the way hearings are conducted?

e. What changes should be made in this regard?

f. Who is responsible for the administration and collection of payments?

## Hearing: Determining Treatment

J AP O IV-1 a. During commitment hearings, is the question ever raised of respondent's capacity to make treatment decisions?

b. IF YES: Under what circumstances?

c. ALL: Is this question ever raised at a separate hearing?

d. IF YES: Under what circumstances?

e. ALL: Would you suggest any changes in practices with regard to raising this question?

f. IF YES: Why and what change?

AP IV-2 a. Is a ruling on capacity to make treatment decisions required if a person is to be committed for treament?

b. Is such a ruling required before treatment can be administered involuntarily after a person has been committed?

c. What recommendations would you make about the need to rule on this question prior to commitment and treatment? BE CAREFUL TO GET ANSWERS TO BOTH ASPECTS OF THIS QUESTION, IF YOU CAN.

J APR O IV-3 a. How customary is it for treatment plans to be presented at hearings? IF NEVER, GO TO LAST PART OF THIS QUESTION

b. Who presents the plan?

c. Are treatment plans ever challenged in the hearing?

d. IF YES: With what effect?

e. What recommendations would you care to make about the presentation of treatment plans during commitment hearings?

J AP O IV-4 a. Who, if anyone, investigates and reports to the court about treatment alternatives?

b. What people or other resources does the judge usually rely on for information about commitment options?

c. What are the advantages or disadvantages of this?

d. What changes, if any, would you suggest?

| | | | |
|---|---|---|---|
| J<br>AP<br>O | IV-5 | a. | What <u>hosptialization</u> alternatives are available to the courts? |
| | | b. | In practice, which of these alternatives are utilized? |
| | | c. | In ordering hospital treatment, to what extent does the court consider hospital resources and conditions? |
| | | d. | Are other alternatives needed? |
| | | e. | IF YES: Why, and what do you recommend? |
| J<br>AP<br>O | IV-6 | a. | Does the court ever commit a respondent to a <u>nonhospital</u> treatment alternative (such as an outpatient program or into another person's care and custody)? |
| | | b. | IF NO: Why not? |
| | | c. | IF YES: What specific alternatives are used? |
| | | d. | ALL: What recommendations would you make regarding commitment for treatment in a less restrictive, nonhospital setting? |
| J | IV-7 | a. | How does a judge decide which hospital or less restrictive alternative should be chosen in a particular case? |
| J<br>AP<br>O | IV-8 | a. | Does the court ever issue an order requiring a respondent to get a particular type of treatment, or requiring that treatment must be given for a specified minimum or maximum time? |
| | | b. | What are your feelings about the court issuing such orders? |
| JC<br>P<br>O | IV-9 | a. | Is a determination made of liability for payment of services when treatment is ordered? IF YES, ASK: How? |
| | | b. | Does this determination affect the types of services made available or the procedures for obtaining services? |
| | | c. | What changes need to be made in this regard? |

## Posthearing

JC Á V-1 These questions will concern several issues that become important after the hearing is completed.

a. What notifications, if any, are given if a respondent is committed? IF ANY, ASK: How are notices given?

b. What notifications are given if a respondent's case is dismissed? IF ANY, ASK: How are notices given?

c. Are these notifications sufficient and useful?

d. IF NO: What changes would you suggest?

J A V-2 a. How often does an appeal take place?

b. Who usually begins this process?

c. Are respondents adequately informed about their right to appeal?

d. What assistance is available to respondents in bringing appeals?

e. Is the appeal process easy enough to understand and use?

f. IF NO TO c OR e, ASK: What changes would you suggest?

J A V-3 a. If an appeal is brought, how soon is it usually heard?

b. If an appeal is brought, how does this affect what happens to the respondent at the treatment facility?

c. Under what circumstances, if any, can a respondent remain at liberty following a commitment order and pending appeal?

c. Should this be changed?

J P V-4 a. After a person is ordered for treatment, what options do hospitals or alternative treatment facilities use in deciding whether or not to examine or admit for treatment?

b. Does this create any problems?

c. What benefit comes from their having those options?

d. What changes would you suggest?

J AP V-5 a. If a facility admits a patient pursuant to a court order, is it under any restrictions regarding the type or extent of treatment it may administer.

b. IF YES: What are the limitations?

c. ALL: Do you feel it is wise to place treatment constraints on a facility? Why?

d. ALL: What treatment-constraining powers should be exercised by the court (or by statute) in your opinion, and at what point in the process?

J AP V-6 a. What information, if any, does the treatment facility provide to the court to inform the court of the patient's progress?

b. IF ANY: What is the reason that this information is provided; that is, is it sent because it is required by statute, it was ordered by the court, or is it provided for some other reason?

c. What additional information does the court need, in your opinion?

d. When should such information be provided?

e. What does the court do with this information?

J APR V-7 a. In your opinion, is the court's oversight of what happens to a committed patient adequate, too much for the facility, or not demanding enough? Why?

b. What would you recommend?

J A V-8 a. What, if any, judicial sanctions are available for ensuring compliance by facilities or respondents with court orders regarding treatment?

b. How frequently are such sanctions used, and with what effect?

c. What recommendations do you have in this regard?

J APR V-9 a. What difficulties arise regarding the transfer of patients?

b. IF ANY: How could these problems be overcome?

J APR V-10 a. What difficulties arise regarding patient discharge?

b. IF ANY: How could these be overcome?

A V-11 a. How far after the hearing is court-appointed counsel responsible to the client? That is, does the client-attorney relationship continue during appeal and treatment?

b. What continuing role do you feel counsel should play following a commitment order?

AP V-12 a. Following commitment, does a patient have the right to refuse treatment? IF YES, ASK: How is the patient notified of this right?

b. Do you feel a patient should have this right?

c. IF YES TO a, ASK: What difficulties does this cause, if any, and how can they be overcome?

APR V-13 a. Under what circumstances does a treatment facility obtain informed consent prior to administering treatment to an involuntarily committed patient?

b. How does this differ for voluntary patients?

AP V-14 a. Excluding those who refuse it, are <u>all</u> patients who are admitted given some form of treatment?

b. IF NO: Why not, and what should be done about this?

APR V-15 a. In your opinion, are the civil and personal rights and safety of committed patients adequately protected?

b. IF NO: Why not, and what should be done about this?

J APR V-16 a. Do patients have access to and use a patient advocacy system to represent their interests?

b. IF NO: Why not?

c. IF YES: What makes the system useful to patients?

d. ALL: Would you recommend any changes in making an advocacy system available? (IF YES) What?

J AP V-17 a. How long are most commitment periods ordered for?

b. To the best of your knowledge, how long does the average patient actually remain in treatment?

c. To the best of your knowledge, are patients typically treated for a correct amount of time, given the help that they require?

d. Should treatment periods be longer or shorter, in your opinion, and why?

J AP V-18 a. In what ways can a patient seek a change in or release from treatment?

b. What is the most effective way?

c. Do you feel that patient's options for seeking change or release are too easy or too hard? Why?

d. How often is a writ of habeas corpus used to seek release?

e. What suggestions would you make concerning these avenues for treatment modification and patient release?

J APR V-19 a. Are the review hearings effective and useful? Why is this?

b. Do they differ in procedure from original commitment hearings, and how?

J AP V-20 a. Are patients' commitment periods typically extended or recertified?

b. What changes do you feel are necessary in the process for recertifying a commitment?

## PART 2. OBSERVATION GUIDE

Observer_____ Date_____

City_____ Place_____

Event_____ Re Case_____

### What to observe during PREHEARING PROCESSING

1. Who initiated the action? (II-1)
2. Where is the action taking place? (II-1)
3. What is being asserted about respondent? (II-3)
4. What documents and other evidence have been filed? (II-3)
5. Have all the necessary papers been filed? (II-2)
6. Do all filed papers contain all the required information? (II-2, II-3, II-14)
7. Is respondent informed of his/her rights? (II-15, II-23, II-25)
8. What options are considered and used for diversion, release, treatment? (II-5, II-7, II-9, II-22)
9. How and when is counsel appointed? (II-17, II-19, II-21)
10. Is treatment being administered? (II-22, II-23)
11. What notifications are given? (II-25, II-26)
12. Is respondent held or discharged? (II-24)

I. Information for Observers About Prehearing Process

1. Who initiated

   (a) emergency - law enforcement officer
   (b) regular - anyone
   (c) criminal - prison psychiatrist

2. Place - petition at courthouse, screening at community mental health clinic

3. What asserted

   (a) emergency - that R is violent and requires restraint and that delay in taking R for examination would endanger life or property
   (b) regular and criminal - that R is MI or inebriate and dangerous to self or others or MR and because of an accompanying behavior disorder is dangerous to others

4-6. Papers filed

   (a) affidavit with court
   (b) examining Dr.'s findings sent to court

7. Notification of rights - notice of hearing to R and R's attorney 48 hours in advance

8. Diversion - first examining Dr. may release R if not committable; the examining Dr. at facility to which R sent after first exam may release R pending hearing if R not committable; detention at community mental health center preferred to hospital

9. Appt. of counsel - appointed upon receipt of examining Dr.'s finding of committability; counsel assigned by clerk at direction of judge; retained counsel allowed

10. Prehearing treatment - reasonable and appropriate medication and treatment; electroshock, experimental drugs, surgery only with written consent

11. Notice - to clerk of superior court of county from which R sent

12. R held or discharged - see #8 above

Observer_____ Date_____

City_____ Place_____

Event_____ Re Case_____

## What to observe during PREHEARING EXAMINATION or TREATMENT

1. Where is the action taking place? (II-7, II-9)
2. What information is given to the examiner? (II-12)
3. What are the examiner's (treater's) qualifications? (II-12)
4. Is respondent informed of his/her rights? (II-15, II-23)
5. Does respondent refuse to cooperate with any part of the process? (II-15, II-23)
6. What information is generated about respondent? (II-14)
7. How is the report to the court formulated? (II-14)
8. What type of treatment is being given? (II-22)
9. Have statutory criteria been met to justify examination or treatment? (II-12, II-22)
10. Is respondent held or discharged? (II-24)

II. Information for Observers about Prehearing Exam or Treatment

1. Where - community mental health center or local qualified physician if no Dr. available at the CMHC; detained in CMHC if available, otherwise detained under supervision at home, in private hospital or clinic, general hospital, or regional MH facility, but not in a jail

2. Info. given to Dr. - not specifically mentioned (NSM)

3. Examiner's qualifications - "qualified physician"

4. Notification of rights - see I-10 and I-7, above

5. R's refusal to cooperate - see I-10, above; right to remain silent NSM

6. Info. generated - whether meets commitment criteria and facts supporting opinion

7. How report formulated - NSM

8. Treatment - see I-10, above

9. Statutory criteria - see I-3, (b) for all routes

10. R held or discharged - Part I-9

Observer_____ Date_____

City_____ Place_____

Event_____ Re Case_____

## What to observe during HEARINGS

1. Where is the action taking place? (III-3)
2. Are proper petitions and certificates available to the court? (II-2, IV-3)
3. Do all filed papers have all required information on them? (II-2, II-14)
4. Are examiners' reports available to the court? (II-2, II-14)
5. Do examiners' reports have sufficient and required information (II-2, II-14, III-7, III-12)
6. Who is conducting the hearing? (III-16)
7. What is the role of the person conducting the hearing?
   a. Does he/she direct questions? (III-16)
8. Is respondent's attorney retained or assigned? (II-17)
9. What are attorney-for-respondent's behaviors?
   a. Does he/she appear to know the facts of the case well? (II-9, II-21)
   b. Does he/she actively challenge examiners' qualifications evidence against respondent? (II-18, II-20)
   c. Does he/she seem to have all the necessary information about LRAs? (II-21, IV-4)
10. Is respondent present? (III-11)
11. Is respondent medicated? (II-22)
12. What witnesses (including examiners) testify? (II-14, II-16)

13. Is respondent informed of his/her rights? (III-4, III-21)

14. Is respondent given opportunity to elect voluntary admission? (III-4)

15. Are necessary criteria met for commitment? (III-5)

16. What rules of evidence and procedure are applied? (III-20)

17. What is examiners' influence at hearing? (III-12, III-13, III-14)

18. Is a treatment plan presented? (IV-3)

19. Are alternative treatment possibilities discussed? (IV-4, IV-5, IV-6, IV-7)

20. Who presents information on alternative treatment options? (IV-3, IV-4)

21. Is question raised of capacity to make treatment decisions? (III-4, IV-2)

22. What are the roles of attorney for petitioner and state's attorney? (III-8, III-9)

23. Is there a jury? (III-10)

24. Is the public present? (III-17)

25. Are continuances granted? (III-19)

26. Are notifications given? (III-21)

27. Are provisions made for payment? (III-22)

III. Information for Observers about Hearings

1. Where - appropriate room not used for treatment of patients at MH facility where R being treated, if located in judge's district, or in judge's chambers; not in a regular courtroom over R's objection if in judge's discretion a more suitable place is available

2. petitions and certs. available to court? - see I-4--6

3. papers have proper info? - see I-4--6

4. examiners' reports with court? - see II-6

5. examiners' reports complete? - see II-6

6. who hears case - District Court

7. role of judge - judge hears testimony

8. R's attorney retained or assigned? - see I-9

9. R's attorney's behaviors - assigned counsel should act as though retained

10. R's presence - with consent of court, R's counsel may waive R's presence

11. R medicated? - see I-10

12. R's behavior - NSM

13. W's - rt. to confront and cross-examine witnesses; reports of examiners are admissable but R's right to cross-examine witnesses shall not be denied.

14. Notification of rts. - see I-7

15. voluntary admission - state policy to encourage voluntary admissions; not a feature of the hearing

16. criteria met? - see I-3,(b) for all routes; clear, cogent, and convincing evidence necessary

17. rules of evid. and proc. - NSM

18. examiner's influence - NSM

19. treatment plan - plan required within 30 days of admission; not part of hearing

20. LRA's - court shall make findings of facts re availability and appropriateness of outpatient treatment before ordering outpatient treatment

21. Who presents LRA info? - NSM

22. Q of R's capacity to make treatment decision? - not inferred from commitment; see I-10

23. Roles of attorneys - state's attorney: Attorneys General at regional facilities to represent state's interests at all hearings and rehearings and to provide liaison and consultation services concerning hearings; R's atty.: see III-9

24. Jury? - NSM

25. Public - closed to public unless R requests otherwise

26. Continuances - on motion of R's counsel sufficiently in advance to avoid movement of the R, for up to 5 days; also, ct. may continue for up to 7 days for production of evid. to help in determining whether R should be ordered to outpatient treatment

27. Notifications - of commitment: copy of order for outpatient treatment to outpatient facility; of dismissal: to facility where R last a patient

28. Payment - county of residence pays costs of exam and hospitalization (if no payment within 60 days after claim, they forfeit and pay treating county $250); county of residence may recover from solvent patients