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The Involuntary Civil Commitment Process in Chicago: Practices and Procedures

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THE INVOLUNTARY CIVIL COMMITMENT PROCESS IN CHICAGO: PRACTICES AND PROCEDURES*

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I. INTRODUCTION

In the decades of the sixties and seventies, the fair and humane treatment of mentally ill persons became a civil rights issue of the first order. The process for involuntarily confining persons in large public mental health institutions came under close public scrutiny and legal attack. At the same time, the development of medications that control many of the symptoms of mental illness gave greater impetus for community-based care and treatment. Partially in response to these trends, then-Illinois Governor Dan Walker established a commission in October 1973, to consider and recommend changes in the state's civil and criminal laws affecting the mentally disabled. Under the chairpersonship of Judge Joseph Schneider of the Circuit Court of Cook County, the commission issued a report[1] three years later that served as the basis for a major revision of the Illinois Mental Health and Development Disabilities Code.[2]

In 1981, the National Center for State Courts,[3] through its Institute on Mental Disabilities and the Law, embarked on a multi-year project examining involuntary civil commitment processes throughout the country.[4] The goal

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* The opinions and recommendations contained in this article are those of the authors and are not necessarily those of the National Center for State Courts, its Institute on Mental Disability and the Law, or the grantor foundations.

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1. Governor's Comm'n for Revision of the Mental Health Code of Ill. Report (1976). [hereinafter cited as Governor's Comm'n Report].

2. ILL. REV. STAT. ch. 91½, §§ 1-100 to -903 (1983).

3. The National Center for State Courts (N.C.S.C.) is a private, not-for-profit organization headquartered in Williamsburg, Virginia, dedicated to improving justice and modernizing court operations throughout the country. It functions as an extension of the state court systems, working on their behalf and in response to their needs.

4. The project was funded by a coalition of private foundations. The major funding base

of the project was to provide information, based on both theory and practice, that could be used by the courts, advocates, and mental health, social service and law enforcement agencies to make the involuntary civil commitment process work as fairly and efficiently as possible. The research involved a comparative analysis of state statutes and case law, a review of the relevant professional literature, and a detailed study of the civil commitment practices and procedures in six metropolitan areas, including Chicago.[5]

Two major products resulted from this work. The first was a series of reports describing the involuntary civil commitment process, identifying strengths and weaknesses, and recommending specific changes in procedures and practices of each site studied.[6] The second was a set of guidelines to facilitate the development and use of fair, realistic procedures for involuntary civil commitment. These guidelines attempt to strike a difficult but important balance between society's interest in the treatment of and protection from mentally ill persons, and the individual's interest in liberty and privacy.[7]

This article is based on the site report, *Involuntary Civil Commitment in Chicago*. It is not intended as either a definitive legal analysis of the Illinois Mental Health Code or a scholarly analysis of the issues. To reference the enormous professional literature on civil commitment as it relates to the manifold issues addressed in this article would have been an enormous task,

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was a grant from the John D. and Catherine T. MacArthur Foundation of Chicago. Funding for local site work in Chicago was a grant from the Chicago Community Trust. Funding to support dissemination of the results and recommendations of the prospect was provided by the Aetna Life and Casualty Foundation.

5. The other areas studied were Columbus, Ohio; Milwaukee, Wisc.; Los Angeles County, Cal.; New York, N.Y.; and Winston-Salem, N.C.

Site work included review of the pertinent statutes and case law, interviews with system participants and observation of hearings. Four members of the project staff spent one week in Chicago in September 1981. All court hearings conducted during this period at the Chicago-Read Mental Health Center and the Illinois State Psychiatric Institute were observed by project staff. Notes taken at the hearings followed a detailed observation guide prepared in advance of the site visit. Interviews were conducted with over 30 individuals who were involved on a daily basis in the civil commitment process. They included judges, assistant State's Attorneys, assistant Public Defenders, representatives from private and public patient advocate agencies and organizations, including the Illinois Guardianship and Advocacy Commission, psychiatrists, mental health system personnel, police officials and members of the academic community. Interview guides were mailed to prospective interviewees so that they could review the areas of concern in advance and prepare for the interviews if they wished to. Most participants were interviewed individually, although some were interviewed in groups. With very few exceptions, all interviews were conducted by two or three staff members.

6. The site reports include: INVOLUNTARY CIVIL COMMITMENT IN THE FIRST JUDICIAL DEPARTMENT, NEW YORK CITY; INVOLUNTARY CIVIL COMMITMENT IN LOS ANGELES COUNTY; INVOLUNTARY CIVIL COMMITMENT IN COLUMBUS, OHIO; INVOLUNTARY CIVIL COMMITMENT IN CHICAGO; INVOLUNTARY CIVIL COMMITMENT IN WINSTON-SALEM, NORTH CAROLINA; and AN EVALUATION OF INVOLUNTARY CIVIL COMMITMENT IN MILWAUKEE, WISCONSIN. Copies of these reports may be obtained from the Publications Department of the National Center for State Courts, 300 Newport Avenue, Williamsburg, Virginia 23185.

7. The general procedural guide, PROVISIONAL SUBSTANTIVE AND PROCEDURAL GUIDELINES FOR INVOLUNTARY CIVIL COMMITMENT, is also available from the Publications Department at the National Center for State Courts.

increased the bulk of this already long article, and added little to the base of knowledge.[8] Rather, this article presents an accurate and representative report of the practices and opinions of the judges, attorneys, physicians, mental health professionals, and administrators who are daily participants in the civil commitment process in Chicago.[9]

After defining some of the terms employed and providing a brief overview of the applicable civil commitment procedures, the findings are presented in roughly chronological order, proceeding from prehearing events to posthearing review. Our conclusions and recommendations follow. It should be understood that this article applies only to the process of civil commitment in the city of Chicago. It is not meant to apply to any other parts of the state of Illinois, or even to Chicago's nearby suburbs. It also relates only to the mentally ill adults of Chicago who are within the civil system of law, and not to prisoners, minors, or persons who are developmentally disabled. The data for this article was gathered during September 1981. The final report was released in review draft at the end of 1981, and is accurate as of that time.

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8. *See, e.g.*, A.D. BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM (1974); B.D. SALES, D.M. POWELL, R. VAN DUIZEND AND ASSOCS., DISABLED PERSONS AND THE LAW: STATE LEGISLATIVE ISSUES (1982); A.A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION (1976); D.B. WEXLER, MENTAL HEALTH LAW: MAJOR ISSUES (1981); Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1107 (1972); Chodoff, *The Case for Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 499 (1976); Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439 (1974); Ennis and Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693 (1974); Gaskins and Wasow, *Vicious Circles in Civil Commitment*, 24 SOCIAL WORK 127 (1979); *Mental Health Law Project, Proposal for Change-Civil Commitment*, 2 MEN. DIS. L. RPTR. 78 (1977); Nedelsley and Schotten, *Civil Commitment and the Value of Liberty*, 46 SOCIAL RESEARCH 374 (1979); *Preparation and Trial of a Civil Commitment Case*, 5 MEN. DIS. L. RPTR. 201, 281, 358 (1981); Szasz, *The Danger of Coercive Psychiatry*, 61 A.B.A. J. 1246 (1975); Whitmer, *From Hospitals to Jails: The Fate of California's Deinstitutionalized Mentally Ill*, 50 AM. J. ORTHOPSYCHIATRY 65 (1980); Zimmerman, Fitch and Barnett, *Involuntary Commitment: the Discerning Eye of the Law*, 5:4 ST. CT. J. 5 (1981).

9. When it is reported that certain events occur in Chicago, it should be understood that this means we were told that those events occur, or that we observed them occurring. If specific sources of information are not cited, it can be assumed that this information was reported by virtually all those who were interviewed and observed. If information came only from certain sources, or if it differed from information from other sources, then the specific source of the information is reported. All sources are reported as generic categories of people, such as judges, attorneys, doctors, mental health professionals, and so on. Specific names are not used because we have attempted to maintain the confidentiality of the information that was provided to us.

In order to achieve greater accuracy, the individuals who served this project in the capacity of advisors and data sources were given the opportunity to review the report before its final release, to detect and correct errors, and to suggest revisions in the report's recommendations. No topic of this complexity can generate a perfect unanimity of opinion, however. Differences in perceptions are acknowledged as much as possible. When conclusions or recommendations had to be fixed in one direction or another, though, the final decisions were made by the project staff and it is they who must be accountable for whatever degree of wisdom or folly was thereby created.

II. TERMINOLOGY

Some terms used throughout this article deserve special comment. The most important is the word "commitment" and its various forms and derivatives. The current vogue is to use the word "hospitalization" because of the strong negative connotations of "commitment." However, we have chosen to use "commitment" for two reasons. First, it is a term that is commonly used and well understood. Second, in Illinois and several other states, commitment and hospitalization are not synonymous. Hospitalization is merely one form that an order of commitment may take.[10] Thus, the choice was made to use the word "commitment" despite the stigma that has been associated with it.

Two other words used frequently in this article are "respondent" and "patient." These words are essentially synonymous for purposes of this report. Technically, a patient is a person who has been admitted for mental health treatment, with or without a court commitment, either as an inpatient or outpatient.[11] A respondent is a person who is the subject of an involuntary commitment proceeding. Generally, the article refers to the person as "respondent" with regard to that person's involvement in legal proceedings before a commitment has been ordered. The person is referred to as a "patient" with regard to treatment.

Finally, there is the term "treatment." Treatment is defined as it is in the Illinois statute: "an effort to accomplish an improvement in the mental condition or a related behavior of a patient. Treatment includes, but is not limited to, hospitalization, partial hospitalization, outpatient services, examination, diagnoses, evaluation, care, training, psychotherapy, pharmaceuticals, and other services provided for patients by mental health facilities."[12]

III. AN OVERVIEW OF THE CIVIL COMMITMENT PROCESS IN CHICAGO

This overview is a blend of both what is required by statute and what actually happens in practice. The implementation of the civil commitment law in Illinois, as in all other states, is not always what would be expected from a literal reading of the commitment statute. While most statutory provisions are adhered to strictly, some are not. More importantly, the system has evolved procedures for working through problems and making decisions in situations that are not addressed specifically by statute.

Overview of the System

The Chicago system for providing treatment to persons who are mentally ill is shown schematically in the figure as follows:

10. Commitment is more nearly synonymous with "court-ordered treatment," but this is not exactly accurate either in a system such as Illinois' in which a patient, though committed, still retains the right to refuse treatment.

11. Outpatients are more frequently referred to as "clients" by mental health professionals, but they will be called "patients" in this article.

12. ILL. REV. STAT. ch. 91½, § 1-128 (1983).

STAGE 1. PERSON HAS A MENTAL HEALTH PROBLEM
- A. Person pursues community outpatient treatment (Go to 2.1)
- B. Person requests hospital treatment (Go to 2.2)
- C. Others initiate action for involuntary treatment (Go to 2.3)
- D. No treatment sought; everybody copes (END)

STAGE 2. EFFORTS ARE MADE TO INITIATE (OR CONTINUE) TREATMENT AS . . .

2.1 COMMUNITY OUTPATIENT TREATMENT
- A. Person receives treatment (Go to 7)
- B. Person referred to hospital as voluntary patient (Go to 2.2)
- C. Person referred to hospital involuntarily (Go to 2.3)

2.2 VOLUNTARY HOSPITALIZATION
- A. Hospital admits and treats as "informal" (Go to 6)
- B. Hospital admits and treats as involuntary (Go to 6)
- C. Hospital refuses to admit; patient may appeal (Go to 1)

2.3 INVOLUNTARY TREATMENT
- A. Police or State's Attorney divert case (Go to 1)
- B. Person decides to seek voluntary treatment; case dismissed (Go to 2.1 or 2.2)
- C. Person remains at home; CMHC examines and does not certify; case dismissed (END)
- D. Persons remains at home; CMHC examines and certifies for hearing (Go to 3)
- E. Hospital examines and releases (END)
- F. Hospital examines and certifies for hearing (Go to 3)

STAGE 3. A COURT HEARING IS SCHEDULED
- A. Symptoms remit, person discharged, case dismissed (END)
- B. "Technicalities" arise; case is continued (Stay at 3) or dismissed (END)
- C. Hearing takes place (Go to 4)

STAGE 4. A COURT HEARING IS HELD
- A. Judge dismisses case; person discharged (END)
- B. Judge commits to hospital for treatment (Go to 5.1)
- C. Judge commits to alternative treatment (Go to 5.2)

STAGE 5. PERSON IS UNDER LEGAL ORDER TO RECEIVE TREATMENT . . .

5.1 IN A HOSPITAL
- A. Treatment status continues for statutory interval; symptoms remit (Go to 7) or continue (Go to 2.3)
- B. Treatment until hospital wishes to discharge patient (Go to 6.1)
- C. Treatment until patient wants to be discharged (Go to 6.2 or 6.3)

5.2 IN A LESS RESTRICTIVE MANNER
- A. Treatment status continues for statutory period; symptoms remit (Go to 7) or continue (Go to 2.3)
- B. Treatment director or court decides hospitalization is required (Go to 3)

STAGE 6. TERMINATION OF TREATMENT IS SOUGHT

6.1 BY THE HOSPITAL
- A. Patient is discharged (Go to 7)
- B. Patient resists discharge by successful appeal to Utilization Review Committee or court (Go to 5.1)

6.2 BY A VOLUNTARY PATIENT
- A. Hospital discharges patient (Go to 7)
- B. Hospital initiates petition for involuntary treatment (Go to 3)
- C. Patient escapes (Go to 7)

6.3 BY AN INVOLUNTARY PATIENT
- A. Treating facility discharges (Go to 7)
- B. Patient appeals commitment decision (Go to 3)
- C. Patient brings habeas writ (Go to 3)
- D. Patient files petition for discharge (Go to 3)
- E. Patient escapes (Go to 5.1 A. or 5.2 A. or 7)

STAGE 7. PATIENT IS DISCHARGED FROM TREATMENT
- A. No further problems (END)
- B. Person recidivates (Go to 1)

The process begins when a person exhibits what appears to be a mental health problem (Stage 1).[13] Many people receive treatment for mental health problems through Chicago's excellent system of community mental health centers (CMHCs) (Stage 2.1). The CMHC operates within a community to provide outpatient treatment services. If the person's condition is such that the CMHC cannot provide effective treatment or if outpatient services are not sought, the person may then be brought to a hospital (Stage 2).

Persons desiring admission to a mental health facility for treatment of mental illness may be admitted upon their request, without making formal application, just as they would enter a hospital for the treatment of any physical ailment (Stage 2.2). Upon admission, these patients are examined and classified as either "informal" or "voluntary," depending upon their condition. If the facility director considers that the individual is clinically

13. Of course, many people have mental health problems to greater or lesser degrees and never seek any type of formal treatment. They, and others who come into contact with them, simply cope with whatever difficulties this may create.

suitable for admission as an "informal" patient, the individual is so admitted[14] and is informed that he or she may leave at any time.[15]

If, instead, the facility director decides to admit the individual as a "voluntary" patient, that individual may be discharged "at the earliest appropriate time, not to exceed five days, excluding Saturdays, Sundays, and holidays," after giving a written notice of the desire to be discharged, unless within that time, an involuntary civil commitment petition and two certificates are filed, stating that the patient requires hospitalization.[16] Hospitals are not obligated to accept patients who wish to be admitted for the treatment of mental problems, but patients who are refused admission have a right to appeal this decision to a hospital administrative committee.[17] In practice, most people who receive hospital care for mental health problems do so as "voluntary" or "informal" patients.[18]

The focus of this article, however, is on those patients who enter the mental health system involuntarily (Stage 2.3). A person is subject to involuntary admission if the individual is "mentally ill and . . . because of his illness is reasonably expected to inflict serious physical harm upon himself or another in the near future or . . . who is mentally ill and . . . because of his illness is unable to provide for his basic physical needs so as to guard himself from serious harm."[19]

Commitment proceedings may be initiated in several different ways. Friends or relatives of the individual may begin commitment proceedings by preparing a petition[20] stating that the individual is in need of commitment. The petition must be accompanied by a "certificate executed by a physician, qualified examiner, or clinical psychologist which states that the respondent

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14. ILL. REV. STAT. ch. 91½, § 3-300(a) (1983). The statute does not define "informal," nor does it provide any criteria to be used by the facility director in making a determination on "informal" status. Consequently, it is possible that facility directors at different institutions may vary as to the factors utilized to determine whether a patient may be informally admitted.

15. *Id.* § 3-300(b).

16. *Id.* § 3-403. The certificates must be executed by a physician, qualified examiner or clinical psychologist who has examined the patient not more than 72 hours prior to admission. *Id.* § 3-602.

17. *Id.* § 3-405(a). A patient denied admission to a mental health facility must be immediately provided with written notice of their right to request review of the denial. The patient then has 14 days to submit a written request for review of the denial. The director of the mental health facility then has seven days from the receipt of this written request to hold a hearing on the denial of admission. *Id.*

18. Private hospitals, in particular, admit individuals as "informal" patients. Most patients admitted to state institutions on their own initiative are classified as "voluntary." N.C.S.C., INVOLUNTARY CIVIL COMMITMENT IN CHICAGO 31 (1982) [hereinafter cited as CHICAGO SITE REPORT].

19. ILL. REV. STAT. ch. 91½, § 1-119 (1983).

20. *Id.* § 3-601(a). Any person 18 years or older may prepare a petition for involuntory commitment. *Id.* §§ 3-601(a), 3-701(a). If a certificate does not accompany the petition, the petition must include the information required in §§ 3-601(b) and 3-603(b). *Id.* § 3-603(b). If a certificate accompanies the petition, only the information required by § 3-601(b) must be provided. *Id.* § 3-601(b).

is subject to involuntary admission and requires immediate hospitalization."[21] Upon receipt of the petition and certificate, the sheriff of the county in which the patient may be found (or the sheriff's designee) transports the patient to the appropriate facility.[22] If a certificate has not been acquired, the patient may be held for no more than twenty-four hours.[23] Even when the petition is accompanied by an examiner's certificate, a second certificate must be completed by a psychiatrist after an examination of the patient, if the person is to be held for treatment for more than twenty-four hours.[24]

Public officials can also begin involuntary commitment proceedings on the basis of their own observations. If there are reasonable grounds to believe a person is subject to involuntary commitment and hospitalization is needed, peace officers[25] may initiate involuntary admission by completing and filing the required petition.[26] However, the certificates still must be obtained to hold a patient for more than twenty-four hours.[27] In practice, police officials or an Assistant State's Attorney, acting on a citizen's complaint, informally evaluate the circumstances surrounding the complaint. The official may divert the case from any further formal involvement by sending all concerned individuals home or referring them to a CMHC. They also may encourage the individual to voluntarily commit him or herself, a step that may be taken even after involuntary commitment proceedings have begun. A court also can initiate involuntary admission proceedings, but again, only for twenty-four hours without petition and certifications.[28]

Finally, involuntary commitment proceedings may be initiated by hospital staff. As is noted above, this ordinarily occurs after a voluntarily admitted patient gives notice of intent to leave the facility.

There are many procedural safeguards built into the system to protect the rights of patients and prospective patients. For example, within twelve hours after the admission of a person to a mental health facility, either by emergency certification or by court order, the facility director must give the person a copy of the petition and a clear and concise written statement explaining the person's legal status, right to counsel, and right to a court hearing.[29] Following admission, any changes in legal status must be fully explained

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21. *Id.* § 3-602. The patient must have been examined by the person executing the certificate less than 72 hours prior to admission. *Id.* In some circumstances the patient may be allowed to remain at home until the commitment examination. *Id.* § 3-704(a).

22. *Id.* § 3-605.

23. *Id.* §§ 3-604, 3-607, 3-704(a).

24. *Id.* § 3-610.

25. Peace officers are defined as "any sheriff, police officer, or other person deputized by proper authority to serve as a peace office." *Id.* § 1-118.

26. *Id.* § 3-606.

27. *Id.* § 3-604.

28. *Id.*

29. *Id.* § 3-205. If the patient does not read or understand English, then some method of communication which the patient comprehends must be employed prior to any hearing so that the patient will be informed of these rights. *Id.*

to the person.[30] Furthermore, anyone twelve years old or over is provided with the address and phone number of the Illinois Guardianship and Advocacy Commission and is assisted in contacting the Commission upon request.[31]

After commitment proceedings are initiated, the next step is a comprehensive physical and mental examination. The examination must occur within twenty-four hours of admission.[32] Persons twelve years old or over, prior to the examination, must be informed "in a simple comprehensible manner of the purpose of the examination; that . . . [they do] not have to talk to the examiner; and that any statements [made] may be disclosed at a court hearing on the issue" of eligibility for involuntary admission.[33] The results of this examination will determine whether the person is immediately released and the case dismissed, or whether a judicial hearing will be scheduled to determine whether the person should be ordered into treatment. At any time prior to the hearing, a respondent may request admission as an informal or a voluntary patient. "If the facility director approves such a request, the court may dismiss the pending proceedings but may require proof that such dismissal is in the best interests of the [patient] and of the public."[34]

If a hearing is necessary (Stage 4), it must be held within five days of admission, excluding Saturdays, Sundays and holidays.[35] If within that time period, the symptoms of the mental health problem remit, the person may be discharged, and the case may be dismissed. To the extent practicable, hearings are held in the mental health facility where the patient is hospitalized.[36]

Respondents have the right to be represented by the counsel of their choice, an attorney from the Guardianship and Mental Health Advocacy Commission, a Public Defender, or other court-appointed attorney.[37] In Chicago, most respondents are represented by an Assistant Public Defender. An Assistant State's Attorney presents the case for the state.[38] Within twenty-four hours of admission, excluding Saturdays, Sundays and holidays, the admission papers are made available to the attorneys involved so that they may begin work on the case.[39]

The respondent is usually present at the hearing, "unless his attorney waives his right to be present and the court is satisfied by a clear showing that

30. *Id.* § 3-206.
31. *Id.*
32. *Id.* §§ 3-604, 3-607, 3-704.
33. *Id.* § 3-208. The explanation must be given by the examiner. Failure of the examiner to provide this information will prevent the examiner from testifying at the court hearing regarding the respondent's admission. *Id.*
34. *Id.* § 3-801.
35. *Id.* § 3-706.
36. *Id.* § 3-800.
37. *Id.* § 3-805.
38. *Id.* § 3-101.
39. *Id.* § 3-609.

the respondent's attendance would subject him to substantial risk of serious physical or emotional harm."[40] In practice, this exception is rarely used. Additionally, the respondent has a right to have the determination of his or her eligibility for commitment made by a jury.[41] Whether the hearing is before a judge or a jury, a respondent cannot be involuntarily committed unless it has been found by clear and convincing evidence that the respondent is:

> Mentally ill and because of his illness [there is] . . . a reasonable expectation that he will inflict serious physical harm upon himself or another in the near future; or . . . because of his illness is unable to provide for his basic physical needs so as to guard himself from serious harm. . . .[42]

If a person is found eligible for commitment, the appropriate disposition must be determined. The director of the facility in which the respondent is hospitalized, or such other person as the court may direct, must prepare a report including information about the appropriateness and availability of less restrictive alternatives to hospitalization, and describing respondent's needs, treatment, and an appropriate timetable for treatment.[43] The judge must then order treatment within either a hospital or an alternative setting (Stage 5).[44]

For people who are seriously mentally ill, few alternatives to hospitalization are available. One option is for the judge to order a patient into the care and custody of a family member, if the family member is willing and able to provide for the patient's treatment needs.[45] Treatment in a less restrictive mode, such as care and custody through an outpatient clinic, as well as treatment in a hospital, will continue as ordered by the judge until either the sixty-day statutorily prescribed commitment period ends, the symptoms remit, or an attempt is made to change the patient's status (Stage 5.2).[46] If during the course of outpatient treatment, it is decided that the patient requires hospitalization after all, a court hearing must be held to determine whether or not hospitalization should be ordered.[47]

When involuntary admission is necessary, a person is usually admitted to a public hospital (usually Chicago-Read or Manteno), although a patient can be ordered to a private hospital, if the hospital is willing to accept the patient.[48] Treatment is made available to the patient for up to sixty days, at the end of which the patient is either discharged or changed to a volun-

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40. *Id.* § 3-806. In practice, this exception is rarely employed.

41. *Id.* § 3-802. The jury consists of six people chosen in the same manner as other civil jurors.

42. *Id.* § 1-119. The standard of proof in involuntary civil commitment cases is clear and convincing evidence. *Id.* § 3-308.

43. *Id.* § 3-810. This treatment plan must be updated during the course of treatment as the patient's condition warrants, but in any event not less than every 30 days. *Id.* § 3-814.

44. *Id.* § 3-811.

45. *Id.*

46. *Id.* §§ 3-812, 3-813, 3-815.

47. *Id.* §§ 3-815(b).

48. *Id.* § 3-811; CHICAGO SITE REPORT, *supra* note 18, at 32.

tary status, or the hospital initiates the process leading to a hearing on the question of retaining the patient.[49] If the patient's symptoms remit, the patient may be discharged prior to the end of the commitment period (Stage 6.1), although the patient may appeal a discharge to the hospital's administrative committee.[50]

Patients whom hospitals continue to treat on an involuntary basis may seek their release in several ways. Patients have the right to appeal the original commitment decision, although this is an infrequent event.[51] A patient may file a petition for discharge, which will guarantee that within five working days, a judicial hearing must be held on the question of whether the patient still meets the criteria of being subject to involuntary admission.[52] Patients also may file a writ of habeas corpus, which may also result in a judicial hearing.[53] Not infrequently, involuntary patients terminate their relationships with the hospital through escape. Such patients are retained "on the books" in the status of absentees until the completion of the commitment period.[54]

The initial extension of a commitment order may be for another sixty days; all subsequent extensions may be for up to 180 days.[55] Patients who are discharged from hospitals are given a small supply of medication and information on how to contact community mental health agencies. If mental health problems arise again, which unfortunately is the case for many former patients, the entire process is begun anew.[56]

IV. FINDINGS

It is impossible to present findings regarding the system for the involuntary treatment of the mentally ill without getting caught up in differences of opinion and conflicting attitudes about mental illness and society's proper response and responsibility. Some people value a system that can provide easily for the treatment of mentally ill individuals because of the obvious need and society's responsibility to respond to the need, even if treatment must be coerced. Other people value a mental health system to the extent that it can protect individuals from hospitalization or from having treatment being thrust upon them involuntarily. For ease of future reference,

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49. ILL. REV. STAT. ch. 91½, § 3-813(a) (1983).

50. *Id.* § 3-903(b).

51. *Id.* § 3-816(b). At best, appeals take from three to four weeks to be heard. By this time, many respondents already have been released from the hospital and have no further interest in pursuing the legal issues on appeal even if release did not render those issues moot. Most respondents are concerned primarily with getting out of the hospital rather than with establishing a point of law. Hence, for the purpose of seeking release from an institution, other legal actions are much more expedient, and few appeals are filed.

52. *Id.* § 3-900. If a patient is not released as a result of this hearing, he or she may request other discharge hearings during the remainder of the commitment period, although the court need not grant hearings on these requests. *Id.* § 3-901(c).

53. *Id.* § 3-905.

54. CHICAGO SITE REPORT, *supra* note 18, at 33.

55. ILL. REV. STAT. ch. 91½, §§ 3-813, 3-815 (1983).

56. CHICAGO SITE REPORT, *supra* note 18, at 33.

the first of these perspectives will be referred to as the "helping attitude" and the second of these as the "liberty attitude."

Some people hold these attitudes in the extreme. Those who are strongly biased toward the helping attitude may contend that mental illness is, per se, sufficient reason to treat an individual against his or her will because that person's capacity for voluntary and intelligent decisionmaking is necessarily impaired. This is not to say that people who subscribe firmly to the helping attitude propound the abolition of all rights, however. They may maintain a strong orientation toward respecting patients, minimizing unnecessary restrictions, and providing humane and adequate care. On the other extreme, those who hold the liberty attitude may contend that mental illness really does not exist. They view people as having wide ranges of behavior to which society must accomodate without interference. Such people, however, agree that behavior harmful to others is cause for concern, but they argue it should be handled through the criminal, rather than the civil, justice system.

Try as one may to balance the helping attitude and the liberty attitude, many situations arise in civil commitment procedures that bring these two attitudes into sharp conflict. Differences in opinion about what decisions may be right or wrong, stem from a fundamental disagreement about the system's objectives as seen in the context of these two contrasting points of view.[57] Thus, disagreements about the value of a civil commitment system frequently can be understood by merely noting these differing attitudinal perspectives. The best system will find ways to accommodate both interests; but conflicts between them are admittedly impossible to avoid and occasionally will force a choice between one or the other. In this article we have attempted to represent the helping attitude and the liberty attitude in equal strength.

A. Prehearing

By far, the major strength of the Chicago system is its network of CHMCs. The community centers offer a wide array of services to all Chicago residents, regardless of financial means. The large number of centers, along with their community orientation, makes it easy for people to receive help and probably lowers the demand for extensive inpatient care. The mental health centers also provide an effective network of aftercare services for patients who are released from hospitals. Patients who can receive effective

57. As an example, suppose that a medical certificate supporting the commitment of a respondent is filed with the court 12 hours later than required by the statute. What should the judge do? A judge may dismiss the case because the hospital did not follow the letter of the law. Or, the judge may order the patient's continued retention in a hospital, despite the "legal technicalities," in order that the patient can continue to be considered for treatment. The action that is considered "right" for the judge depends upon whether one has a stronger attitude toward helping a person or protecting a person's liberty interests.

treatment through outpatient clinics may be less likely to reenter the judicial system for involuntary commitment.

As a result of these extensive community services, and a commitment statute that sets a rigid criterion for involuntary treatment, a majority of those entering the Chicago mental health system are either not admitted by the hospital, enter on a voluntary basis, or are admitted and subsequently discharged before a hearing is held. The prehearing is the total extent of their involvement in the involuntary civil commitment process. Consequently, those persons who reach the judicial hearing stage are usually seriously mentally ill.[58] This is a major reason for the high percentage of hearings that result in commitments to hospital inpatient facilities.

1. Initiating Mental Health Treatment

Most involuntary commitments begin outside a hospital setting. In these instances, Chicago police officers are called upon to provide transportation to a public hospital and, in some cases, to serve a screening function as well. The latter role occurs most frequently in response to a call for assistance from a family member or concerned citizen. When the situation does not appear to be an emergency, police officers or police dispatchers frequently direct the caller to contact the office of the State's Attorney to obtain a court writ authorizing the respondent's detention.[59] In those cases in which the police respond to the call, they decide on the basis of their own observations, whether the respondent's behavior warrants formal treatment through the mental health system, the criminal justice system, or diversion to an informal means of treatment. If the police decide that the person should be examined at a hospital, they attempt to have the person who made the initial call act as petitioner rather than assume that responsibility themselves. In addition, police on the beat may witness behaviors that they think indicate a mental health problem. In these cases, the police are authorized to take respondents into custody and bring them directly to mental health facilities (usually an inpatient facility.)[60]

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58. Of course, this characteristic of the Chicago system has potential drawbacks as well. Assuming that any person who enters the system is seriously ill may be a grave error. Simply because respondents are scheduled for a hearing does not mean that they are in need of mental health treatment. Even though the CMHCs effectively screen out most of the less serious cases, the challenge to the judicial system is to evaluate cases carefully, free of any unwarranted predisposition toward commitment.

59. The Assistant State's Attorney reviews the case with the complainant and decides whether or not it is appropriate for the mental health system. If the Assistant State's Attorney does not divert the case at this point, he or she has the complainant initiate a petition and thereupon takes the case before a judge. If the judge issues a writ authorizing the respondent's detention, the police are notified to take respondent into custody and transport him or her to a hospital for examination.

60. ILL. REV. STAT. ch. 91½, § 3-606 (1983). The statute permits the police to take a person to a mental health facility when there are reasonable grounds to believe that the person needs to be hospitalized immediately to protect the person or others from physical harm. *Id.*

In performing these transportation and screening functions, Chicago police officers provide a valuable and difficult service, and many of our interviewees commended individual officers for their assistance and understanding. In recognition of the significance of these roles to the community, training should be made available to police officers concerning the nature of mental health disorders, techniques for communicating and handling mentally disordered persons, and the community resources that are available.[61]

When respondents are transported by the police to a hospital for a mental health examination, they are considered to be in "protective custody." The police have negotiated a "no decline agreement" with several hospitals in the Chicago area, meaning that the hospitals have agreed not to refuse summarily to examine patients brought to them in this manner. If the respondent has engaged in a criminal misdemeanor, an officer may take respondent for a mental health evaluation and await the hospital's decision of whether or not to admit. If the hospital decides to admit, the police ordinarily do not pursue the misdemeanor charges. If criminal behavior of a felony nature is involved, the respondent always is taken directly for an appearance before a judge. Mental health treatment, if indicated, then occurs by means of the criminal justice system—most frequently at the Cook County Jail.

A small proportion of the involuntary commitments begin when respondents arrive at a hospital or mental health center accompanied by family members or other concerned people. After going through a psychiatric examination, the respondent may prefer to go home, but the psychiatrist may decide the person is in need of hospitalization. The psychiatrist, or more frequently one of the people who accompanied the respondent to the mental health facility, then initiates a petition and medical certificate and the patient is admitted to the hospital.

Mental health treatment also may be initiated by a judge based upon observation of an individual in court.[62] According to the report of the Governor's Commission for Revision of the Mental Health Code of Illinois, the intent of this statutory provision is to enable a judge to initiate mental treatment for a person who might require immediate admission during the judicial process, and to allow a person accused of a crime to be treated in a mental health facility as an alternative to incarceration.[63] It has been alleged by

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61. An inexpensive and minimal way in which to do this would be to arrange informal briefings for the beat officers, given by professional staff of the community mental health centers.

62. ILL. REV. STAT. ch. 91½, § 3-607 (1983). The court must have "reasonable grounds to believe that a person appearing before it is . . . in need of immediate hospitalization to protect such person or others from physical harm. . . ." Additionally, the court must include in its order for detention the facts "in detail" upon which the decision to detain is based. *Id.*

63. Governor's Comm'n Report, *supra* note 1, at 53-4. For the sake of completeness, it should be noted that a small number of civil commitment patients have been transferred through other procedures from the criminal justice system. These are special cases to which no further attention will be given in this article.

some attorneys, however, that this provision in the statute is used in civil commitment cases that fail to meet all statutory requirements, such as those in which information is incomplete in a petition or certificate. Rather than dismiss a case, the judge can use this provision of the law immediately to initiate a new commitment proceeding, thereby retaining custody of the respondent.[64]

2. *Petitions and Certificates*

The petition serves as an allegation by the petitioner that the respondent is in need of treatment.[65] Certificates are statements filed by experts (who may be certified social workers and registered nurses, physicians, psychiatrists, or psychologists) in support of the petitioner's contention.[66] To detain an involuntary respondent more than twenty-four hours, in either an emergency or nonemergency situation, two certificates must be filed, one of which must be signed by a psychiatrist.[67]

The comments regarding petitions and certificates in Chicago strongly reflect the divergence between the "liberty" and the "helping" attitudes discussed earlier. For example, there is strong disagreement about the quality of the information contained in these documents and the consequences of having deficiencies[68] in them. Hospital staff tend to report that when the petitions and certificates are deficient in some way, judges tend to dismiss the cases, thereby frustrating attempts to give treatment for people who need it. The Assistant Public Defenders and other attorneys, on the other hand, agree that these documents occasionally have legal deficiencies. But they report that judges usually overlook such deficiencies, continue to hold the respondent in custody, and hear the case on its merits. In their opinion, this deprives the respondents of their statutory legal protections.[69] Both are

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64. All of the involuntary admissions referred to above are authorized by the Illinois statute as "emergency" admissions. ILL. REV. STAT. ch. 91½, Art. VI (1983). In all of these, it is alleged not only that the person is subject to involuntary admission but also that he or she is in need of *immediate* hospitalization. The Mental Health and Development Disabilities Code also provides for admission to a hospital in a nonemergency situation subsequent to a petition by another person which describes the reasons for court ordered admission. *Id.* §§ 3-700 to -706. The nonemergency procedures are seldom used, however, in large part because persons not requiring immediate hospitalization can obtain mental health care from the CHMCs.

65. *Id.* §§ 3-601, 3-603, 3-701. The basic petition must include at a minimum a detailed statement of the reasons why the person should be involuntarily admitted; the names and addresses of close relatives, or if none are identified, the friends of the person; the relationship of the petitioner to the person and whether the petitioner has a legal or financial interest in the matter; and the names, addresses, and phone numbers of witnesses who could prove the assertions made in the petition. *Id.* § 3-601(b).

66. *Id.* §§ 3-602, 3-702, 3-703.

67. *See supra* note 16 and accompanying text.

68. ILL. REV. STAT. ch. 91½, § 3-610 (1983).

69. *Id.* §§ 3-601, 3-602, 3-604, 3-608, 3-610, 3-702, 3-703, 3-704.

probably correct in their perception, in that judges who tend to adhere to the "helping" attitude generally consider the substance of the petition as more important than its form and would frequently detain a respondent where the deficiencies are only formal; whereas judges who adhere to the "liberty" attitude, give greater emphasis to the protection of the respondent's legal rights.

Additionally, there was agreement among a number of interviewees that information provided in the petitions is sometimes general and overly reliant upon unsubstantiated opinion, particularly with regard to whether the respondent is dangerous or is substantially unable to care for his or her basic physical needs. Most professionals agree that although psychiatrists are certainly more accurate in detecting mental illness, their conclusions about the dangerousness or the ability of a person to care for himself are often no more reliable than those of lay individuals.[70] In many instances, dangerousness can be more accurately assessed on the basis of reports about the respondent's behavior "on the streets" rather than from results of an examination in a doctor's office. This was recognized in the Governor's Commission Report, which commented "that it would be difficult to consistently and accurately apply the subjective evaluation of dangerousness or helplessness . . . without the support of an overt act or threat."[71] Despite this conclusion, the current statute does not require that the petitioner report an overt act or threat.[72] A commitment can proceed on the basis of lay opinion, expressed in a petition, without citation to overt behavior to support these conclusions.

Although attorneys have argued for requiring a report of an overt act, doctors are pleased that this is not a statutory requirement. Doctors observe that people may behave in ways that strongly suggest violence to themselves or others but that are not explicitly violent or threatening. They cite examples of people who speak about going to join their dead parents, or of a man whose wife is deceased and who talks cheerfully about re-uniting his children with their mother. While statements such as these are neither violent acts nor explicit threats, they can precede tragic acts of violence by people who are in a psychotic state. Empirical research, however, suggests that the incidence of actual violent acts following such statements is small. Therefore, attorneys prefer the overt act requirement. Doctors, on the other hand, feel

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70. *See, e.g.*, Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U. PA. L. REV. 439 (1974); Ennis and Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 692, 711-17 (1974); Middleton, *Predicting Violence: Law Psychiatrists be Seers?*, 66 A.B.A. J. 829 (1980); Wenk, Robison & Smith, *Can Violence be Predicted*, 18 CRIME & DELIN. 393 (1972); *see also* A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION 27-33 (1975).

71. Governor's Comm'n Report, *supra* note 1, at 16.

72. ILL. REV. STAT. ch. 91½, § 3-601(b)(1) (1983). *Cf.* WIS. STAT. ANN. § 51.20 (1)(a)(2) (West Supp. 1980-1981) (evidence of overt act required to be alleged in a petition).

that the risk indicated by such statements is sufficiently great to justify initiating a commitment, and they prefer that overt acts and threats not be required on petitions. Thus, depending on one's perspective, the absence of a requirement that overtly dangerous behavior or threats be proven can be seen as a strength or as a weakness of the Chicago civil commitment process.

A middleground, recommended by the report on which this article is based, may be for courts to encourage that specific overt acts or threats be recorded on mental health petitions whenever possible. This would limit the risk that a person may be taken into custody on the basis of the conclusory statements and unsubstantiated opinions of a petitioner, without curtailing the court's authority to respond in an exceptional case.[73]

The problems that occur in petitions are magnified by the common practice of repeating, without elaboration, the allegations set forth in the petition and the first medical certificates. The examiner's certificates ideally should present independently both facts and statements of opinion. Attorneys in Chicago, however, report that certificates more commonly contain only statements of fact or statements of opinion but not both.

3. Prehearing Determination

In practice, virtually all respondents receive their guaranteed hearing within the statutory five-day period,[74] although many hearings result in continuances that delay final dispositions. It is widely agreed that the five-day period represents a good balance between minimizing the amount of time a person may be held without a hearing and maximizing the acquisition of information and preparation necessary for a meaningful judicial hearing. The five-day period seems to be most constraining for the Assistant Public Defenders, who find it difficult to prepare their cases adequately and completely in this amount of time. This short time interval, they report, makes it difficult to arrange for witnesses who will testify at the hearings on respondent's behalf. Mental health staff apparently have no difficulty in examining patients and preparing their necessary reports within the allowed time. Overall, the short detention period and the statutory authority for allowing respondents to remain at home prior to the hearing[75] can be considered strengths of the Chicago system.

4. Notification of Rights

A respondent usually learns of his or her legal rights from two sources: the hospital examiner and the attorney, usually the Assistant Public Defender.

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73. CHICAGO SITE REPORT, *supra* note 18, at 55.

74. ILL. REV. STAT. ch. 91½, § 3-611 (1983).

75. *Id.* § 3-704(a). As noted above, however, the home placement option is seldom used. *See supra* note 21.

The hospital examiner is required to inform respondent of the purpose of the examination and of respondent's right to remain silent.[76] If the hospital examiner certifies respondent for admission pending a judicial hearing, the respondent will be informed of additional rights, pursuant to the policy of the particular hospital and the statutory requirements. Attorneys who are assigned to represent these cases generally will repeat these rights to the respondent during their first meeting.

Although it appears that all respondents receive information about their legal rights and the civil commitment process, many questions are raised about the efficacy of this procedure for the respondent.[77] Mental health staff frequently consider such communications to be a waste of time, believing that respondents are for the most part too ill, too anxious, and generally too confused to comprehend the rights and process about which they are being informed. Staff personnel say that overwhelming such people with confusing papers and verbal gibberish merely exacerbates an already strained situation.

Assistant Public Defenders, on the other hand, express the opinion that respondents often are not informed adequately about the civil commitment and hospitalization process.[78] These attorneys report that many of the respondents they meet with in the hospital do not understand what is happening to them, what is going to happen to them during the prehearing and hearing procedures, how they can request various types of assistance, and how they can request release from the hospital. Assistant Public Defenders report that their clients often think that public defenders are part of the hospital staff, and that as a result, many seem to resist (or at least do not cooperate with) counsel's assistance. Non-lawyers agree that few respondents really understand their legal rights or how to make use of them, and suggest that more individual and thoughtful counseling with each respondent is necessary.

Typically, statements of rights seem to be communicated to patients more to satisfy the letter of the law, than to provide patients with information. To be effective, these statements should be presented in simple language. Additional information can be available and provided to patients who request a more thorough understanding of their rights. Moreover, a patient's understanding of these materials can be enhanced significantly by a personal discussion and explanation. This should include information about hospital procedures, what will happen during the prehearing and hearing processes, and how to request services. In offering such information, however, hospital staff and respondent's counsel should take a respondent's condition and in-

76. ILL. REV. STAT. ch. 91½, § 3-208 (1983).

77. CHICAGO SITE REPORT, *supra* note 18, at 45-47.

78. Explanations of the patient's rights to some extent encompass an explanation of the process that the person is about to experience.

terest into account. Patients should be able to decline or defer the explanation of their rights if they are uninterested.[79]

5. Voluntary Admissions

As noted previously, Illinois law creates three classes of mental health admission—informal (under which a patient is entitled to leave the facility at any time),[80] voluntary (under which a patient consents to treatment, but may be held up to five days after requesting release),[81] and involuntary.[82] When a petition for involuntary civil commitment has been filed, the respondent is often encouraged to apply for voluntary admission prior to the commitment hearing.

It is generally acknowledged that everyone benefits when a patient is in the hospital on a voluntary rather than an involuntary status. From the respondent's point of view, voluntary status generally brings more privileges and a more satisfying experience as a patient. It also enhances the likelihood that therapy will have a positive effect upon the patient and avoids the stigma of a public record of involuntary commitment. Hospital staff also prefer to work with patients who are on voluntary status because of the greater possibility of a successful therapeutic outcome. Additionally, the voluntary status means considerably less paperwork and less time spent in hearings for the hospital staff. Thus, from both the liberty and helping perspectives, and from the standpoint of reducing costs for the public at large, the opportunity for short-circuiting the involuntary commitment process through a voluntary admission is one of the strengths of the Chicago system.

Some Chicago judges were concerned, however, that respondents were being pressured into making "voluntary" applications by hospital staff. The Illinois Code strongly discourages coercing patients into seeking voluntary admission to a facility,[83] and a form regularly filed by counsel following the filing of an appliction for voluntary admission requires confirmation that the attorney has explained "to the respondent his/her rights as a voluntary patient, [and] . . . his/her right to demand a court hearing. . . " on the involuntary commitment petition. The attorney must also state that the filing of the voluntary admission application "is the respondent's free willing

79. Patients' lack of interest in their rights may be an indication that to apprise them of such rights would be anti-therapeutic. Thus, the system should provide the patient with an option to decline or defer the explanation of rights. CHICAGO SITE REPORT, *supra* note 18, at 59.

80. ILL. REV. STAT. ch. 91½, § 3-300 (1983).

81. *Id.* §§ 3-400 to -405.

82. *Id.* §§ 3-600 to -706.

83. *Id.* § 3-402. This provision states that physicians, qualified examiners and clinical psychologists may not try to convince a person to voluntarily admit himself by indicating the prospect of involuntary admission unless someone qualified under § 3-602 is prepared to execute a certificate for involuntary admission and the person is advised of his rights upon an involuntary admission. *Id.*

and informed act."[84] Through this process, judges are assured by the attorneys that patients are not being talked into treatment against their wishes and without a court hearing.[85]

Mental health patients' advocates have been concerned about the same

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84. The following form is used by the courts to confirm that the patient has been explained his rights.

IN THE CIRCUIT COURT OF COOK COUNTY
COUNTY DEPARTMENT --- COUNTY DIVISION

IN THE MATTER OF)

Confirmation of Attorney's Interview

I, _____, an Assistant Public Defender,/ staff attorney of the Guardianship and Mental Health Advocacy Commission/, attorney in the private practice of law have interviewed _____ the respondent herein prior to the filing of his/her application for admission as a voluntary patient pursuant to the provisions of Article IV of the Mental Health and Developmental Disabilities Code. I have explained to the respondent his/her rights as a voluntary patient. Further, I have informed the respondent of his/her right to demand a court hearing on the question whether he/she is subject to involuntary admission.

It is my opinion that the application for voluntary admission is the respondent's free, willing and informed act.

Dated:_____

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85. In some cases, judges still require the patient to come to court so the judges can be personally satisfied that the application for voluntary admission was made willingly.

issue from a different perspective. They point out that while treatment as a voluntary patient is much preferable to treatment as an involuntary patient, a person who has never been a patient has virtually no information upon which to make an intelligent decision about voluntary mental health treatment. Consumers of most goods and services in our society can shop around, see samples, and make trial purchases before they are "committed" to a decision. Patients' advocates would like to see respondents given a tour of mental health facilities, introduced to doctors and other mental health staff, and given a full explanation of potential treatments before they are asked to elect voluntary admission.

It should also be noted that following the submission of an involuntary commitment petition, a respondent is entitled to apply for voluntary admission. Nevertheless, the application may not be granted automatically. Even if the application is accepted by the facility director, the Assistant State's Attorney can object to the patient's voluntary admission. If an objection is filed, the application must be reviewed by the court to determine whether voluntary admission is truly in the interests of both the respondent and the public.[86] This requirement for judicial review is intended as a safeguard against patients abusing the voluntary application privilege by using it as a vehicle for obtaining release within a five-day period.

Because elections to seek voluntary admission are occasionally disputed, some hospitals have begun routinely to complete the two mental health examinations and certifications required for involuntary commitments, even if the respondent has chosen to seek voluntary admission. Hospital staff do not like this procedure but have chosen it so that they can effectively advocate involuntary commitment if respondent's election of voluntary admission is denied by the court. Hospital staff view this as an inefficient use of resources because it forces the hospital to perform the second examination within a 24-hour period, which may not be useful for either the hospital or the patient. Also, it requires that the second examination be performed by a psychiatrist, which may not always be the best approach from a treatment perspective. Furthermore, it requires that the examination begin with the disclosure of the patient's right-to-silence, which many examiners dislike under any circumstances and which seems especially inappropriate after the patient has agreed to seek a voluntary admission.

Advocates for mental health patients do not agree that the practice of having two examinations is necessarily a bad use of resources, however, and recommend that this become a standard requirement in all cases in which the respondent elects voluntary admission. These advocates assert that it is considered prudent in virtually any other medical procedure for a person to seek another opinion before undergoing any serious medical treatment. Similarly, a respondent may be better advised after talking with two examiners. The second medical examination also may provide the court with

86. ILL. REV. STAT. ch. 91½, § 3-801 (1983).

useful information for deciding whether or not to allow the voluntary application.

Hospital staff object that this reasoning implies that hospitals are trying to retain patients who do not really need hospitalization. They contend that this is far from the truth in these days of scarce resources.

6. *Pre-hearing Examination*

As discussed above, two examinations, including at least one by a psychiatrist, are required to retain a respondent in custody and bring an involuntary commitment proceeding to a formal judicial hearing.[87] The examination usually results from the core of evidence presented at the hearing and, thus, is of critical importance. Examinations are conducted promptly in Chicago, and the certificates of examination are properly filed. But, a number of serious concerns were evident in the interviews with Chicago legal and mental health professionals.

a. Independent Examination

Because of the importance of the pre-hearing examination, respondents are entitled to request an examination by an independent examiner.[88] In practice, however, independent examinations are rarely conducted. One reason is that no mechanism has been established for funding independent examinations. Moreover, requesting an independent examination usually means that a hearing will be delayed at least one week, which is a major disincentive for respondents to request these examinations. Finally, the independent examiners are appointed by judges rather than chosen by respondents, and they usually are on the staff of the Illinois Department of Mental Health and Developmental Disabilities. Chicago attorneys feel that these examiners are not "independent," because they are affiliated with the regular hospital examiners, have access to and use of the other examiners' notes, and probably discuss the cases with the other examiners. This criticism is not meant to imply that the Department's examiners have an unfair bias toward hospitalizing people; it is only meant to suggest that Department examiners are less likely than others to disagree with assessments made earlier by their colleagues.

The availability of an independent examiner is important in establishing the reliability of psychiatric testimony. Because the testimony of examiners is so influential in these cases, testimony that fails to corroborate the original psychiatric conclusions will be an important factor in the presentation of respondent's case. The mechanics and circumstances under which independent examiners can be made available must be worked out for the city of Chicago. Other cities have used court-appointed private psychiatrists, who are made available to respondents and are paid by the state. To minimize

87. *See supra* notes 60-62 and accompanying text.

88. ILL. REV. STAT. ch. 91½, § 3-804 (1983).

costs, the psychiatrists need not be involved in every case. They can be "on call" at the hospital or in a nearby office, available to provide an independent examination within a couple of hours if so requested by the Assistent Public Defender. The Illinois statute intended that this important resource be available to respondents. Because it currently is not truly available, some mechanism should be established whereby an independent examination can be provided by a qualified examiner not employed by the Department of Mental Health and Development Disabilities.

b. Language Barriers

Many foreign-born doctors work for the state health facilities in the Chicago area. While most foreign-born doctors are highly regarded, and while their medical qualifications are readily acknowledged, problems occur when these doctors are not fluent in English. A doctor's lack of fluency in English—particularly in idiomatic English—makes it difficult for respondents to communicate with the doctor, and can lead to significant misunderstandings and misinterpretations of statements made by respondents. Aside from possibly leading to inaccurate medical observations and diagnoses, a poor level of communication between doctor and patient can make already anxious respondents uncooperative and can act as a barrier to establishing a positive therapeutic environment, thereby discouraging voluntary admissions. In addition, it can make reports and testimony difficult for the court and counsel to understand. Accordingly, doctors who are to examine respondents and prepare medical certifications should be required to display at least a minimal fluency in both oral and written English.

c. Right to Remain Silent

When an examination is being performed for purposes of certification, the examiner must tell respondent the purpose of the examination, that what he or she says may be disclosed in court, and that he or she has the right to remain silent during the examination.[89] If this is not done, the examiner is not allowed to testify in court.[90]

Most doctors and other examiners do not like to begin examinations by "reading the rights" to respondents. They believe that this instantly destroys any chance for a candid exchange in an atmosphere of trust and support, creating instead an attitude of resistance and defensiveness. A significant minority of others disagree. In their opinions, respondents are pleased that

89. *Id.* § 3-208.

90. *Id.* The statute does not provide any exceptions to this requirement. However, the Governor's Commission Report apparently did not intend for the requirement to be absolute. For example, if the need for commitment becomes apparent only after an examination had begun, it would be appropriate at that time for an examiner to give this information to the person and continue with the examination. Furthermore, the Report specifies that the disclosure requirements ought not to apply "to the traditional therapist-patient relationship. . . ." Governor's Comm'n Report, *supra* note 1, at 38.

an examiner levels with them in this manner, resulting in an enhanced atmosphere of trust and cooperation. Few examiners, regardless of attitude, report circumstances in which respondents refuse to talk with them as a matter of legal right, although many respondents refuse to talk because they are either too hostile or too sick to communicate. Assistant Public Defenders and other attorneys feel strongly that the disclosures are important. They point out that the respondent's statements become part of the court's public record and are used by succeeding examiners. They feel that the disclosure poses no problem for most examiners.

Many examiners reportedly do not always make the required disclosures to respondents prior to the examination. Some are unaware of or do not fully understand the requirement, while others consider the requirement inappropriate and ignore it as a matter of principle. Some examiners reportedly ignore the requirement to assure that they will not be required to testify in court. Other examiners go so far as to indicate on the certificates that they have made the disclosures, even though they routinely do not do so. Counsel for respondents report that judges do not consistently enforce the statute with regard to the required statements about respondent's right to silence during the examination.[91]

In effect, the system appears to work on a "gentleman's agreement" of sorts: examiners are expected to follow the statute with regard to disclosures as closely as possible, but rarely is there any consequence if they do not. Few, if any, would endorse a change in either the practice or the statute; nevertheless, there is a consensus that the certificate should record accurately whether or not the respondent was properly informed of his or her rights. One way of accomplishing this would be to change the form of the certificate so that the examiner is required to indicate this information clearly and honestly.

d. Inadequate Examination Reports

Many attorneys and psychiatrists in the Chicago system feel that psychiatric reports and certifications sent to the court are too conclusory in their language. The underlying problem seems to be caused by attempts to communicate psychiatric findings in lay language. Attorneys fault psychiatrists for communicating in technical jargon, but psychiatrists point out that the process of translating technical terminology into more common language forces them into making interpretations and conclusory statements. Attorneys and psychiatrists seem to agree that the best reports would be those in which psychiatrists could report their objective findings in their usual manner and

91. Counsel for respondents report incidents where examiners have admitted in court that the right to silence was not disclosed by the examiner, but the judge nevertheless committed the respondent. On the other hand, some judges have dismissed cases because the disclosures were not properly made by the examiners. The Illinois appellate courts have held firmly that disclosures are required prior to both certifying examinations for a commitment to be valid. *See In re* Collins, 102 Ill. App. 3d 138, 429 N.E.2d 531 (1981).

then follow up with an interpretation and conclusion presented in lay language.

Judges fault the lack of useful information about the respondent's social history and background. They would like a more extensive social history to be performed as part of the prehearing examinations and to have the results available to them at the time of the hearing. It should be noted that such a social investigation is required for respondents alleged to be unable to care for their basic physical needs.[92] In practice, however, this information seldom is provided as intended by statute.

The examination report is the core of the evidence presented at the commitment hearing. When it is inadequate, the risk of an incorrect judicial decision escalates sharply. Consequently, examining psychiatrists should be encouraged to provide a full standard mental status examination report as part of the medical certification.[93] This report should include both the factual basis on which the psychiatric conclusions are drawn and the conclusions themselves. Whenever possible, this report should be supplemented by an interpretation of the information in lay language.

In addition, prior to the judicial hearing, the mental health facility should be required to make an investigation of respondent's social and family situation and provide the findings to the judge. Mental health staff explain that preparing such a report within the five-day prehearing period is extremely difficult, especially with the diminished resources under which they currently must function. Some compromise is possible. For example, it makes little sense to perform a vigorous social history investigation for respondents who, if they are to receive treatment, certainly will need to be hospitalized. Full investigations might be undertaken selectively, in those cases appearing most likely to necessitate them. In cases in which the information was not obtained, but in which it is deemed to be important, a seven-day continuance can be ordered during which the necessary investigation can be completed. The obvious disadvantage of a continuance is the respondent's continued detention. But, detention for purposes of exploring alternative community placements is preferable to what may presently happen: prolonged commitment to a hospital because treatment is needed and no social investigation has been performed.

7. *Prehearing Treatment*

In practice, most respondents are given medication shortly after they are admitted to hospitals. This medication is continued during the time that they

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92. ILL. REV. STAT. ch. 91½, § 1-119(2) (1983).

93. The question of what constitutes a "standard" mental status examination undoubtedly will generate differences of opinion among psychiatrists. This should not detract, however, from the value of this recommendation. After consultation with the mental health community, it may be useful to define carefully what a "standard" examination is, either in statute or by court rule.

are presented for judicial hearing.[94] Controversy exists over whether or not mental health patients ought to be medicated at their judicial hearing. On one hand, a patient who is medicated effectively will frequently make a better appearance before the judge and, thus, will not display symptoms of psychosis that may influence a judge to order commitment. On the other hand, medication, particularly overmedication, can work against a respondent during a hearing. Medication sometimes will cloud a person's thinking, rather than sharpen it, and diminish the respondent's ability to testify effectively on his or her own behalf. Undesirable side effects of some medications also cause respondents to appear gravely mentally ill or unable to control their actions. The prompt provision of treatment will benefit the respondent in most instances and will reduce the need for lengthy and expensive hospitalization. However, to assist judges in making commitment decisions, they should be informed of all medication that was provided to the respondent during the prehearing period, and the probable effect that the medication currently has on the respondent and his or her ability to testify in court.

8. Prehearing Discharge and Dismissal

A strength of the Illinois system is that the involuntary commitment process may be halted quickly when such a commitment appears to be unnecessary or ill-considered. If either of the two required examiners does not find that the respondent meets the statutorily prescribed criteria, the respondent is immediately released and the case does not proceed to a judicial hearing. If the respondent's symptoms remit during the period of time preceding the judicial hearing, the hospital will discharge the patient. In this situation, if the case has already been set for a hearing, it will be dismissed when it is called. Similarly, if a respondent consents to a voluntary admission, counsel confirms that the decision is indeed voluntary, and the court concludes that such an admission is of benefit to the respondent and the public, the case is dismissed.[95]

B. Counsel for the Respondent

1. Appointment of Counsel

Virtually every respondent facing possible involuntary commitment in Chicago is represented by counsel. For all intents and purposes, counsel is assigned by the court at the time the petitions and certifications are filed.

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94. The Illinois Code permits hospitals to treat respondents as soon as a first examination and certificate have been completed. ILL. REV. STAT. ch. 91½, § 3-608 (1983). It also requires, however, that the respondents be informed of their right to refuse medication. If a respondent refuses medication, drug treatment may proceed if it is deemed necessary to prevent serious harm to the respondent or others. *Id.*

95. *See supra* note 85 and accompanying text.

The vast majority of respondents in Chicago are represented by Assistant Public Defenders, although some are represented by privately retained counsel, privately appointed counsel, or attorneys from the Guardianship and Advocacy Commission.[96]

Respondents in Illinois have the right to represent themselves at commitment hearings, with the consent of the court.[97] In practice, however, this rarely happens. It is less rare that respondents will reject the assistance of counsel, usually because they are suspicious of the Assistant Public Defender, but sometimes simply due to their generally confused state. In these situations, judges most frequently give the respondent the right to present his or her case in court, but request that the Assistant Public Defender stay at the respondent's side in court to "help out." Assistant Public Defenders report, however, that when a respondent wishes to represent himself or herself, the attorney is occasionally directed to provide legal assistance *if and only if* the respondent requests help. This causes problems because respondents frequently do not know when they need help. Counsel must remain silent at a hearing, for example, while evidence to which counsel should object is introduced. Thus, placing restrictions on the Assistant Public Defender's freedom to "help out" in these cases can cause significant difficulties.

Appointed counsel in Chicago are responsible for their clients primarily during the prehearing and hearing phases of the commitment process. The statute does not require counsel to maintain the attorney-client relationship once a patient has been committed to treatment.[98] Similarly, in practice it appears that attorneys do not attempt to continue representing respondents after commitment.

2. *The Role of Counsel*

In the extremes, two roles are possible for counsel who represent respondents in voluntary civil commitment cases. Attorneys may play the role of staunch *advocates,* battling in court for that which their clients desire—usually prompt discharge from the hospital and dismissal of the case. At the other extreme, attorneys may play the role of guardian ad litem. In this role, they determine and work for what they feel is in their client's best interest. This may be a discharge from the hospital, as the client wishes, or continued custody and treatment, which may be contrary to the client's

96. The Illinois statute requires that counsel shall be appointed for indigent persons. ILL. REV. STAT. ch. 91½, § 3-805 (1983). In practice, no effort is made to determine whether or not a respondent is indigent; unless a respondent has retained a personal attorney, the court appoints counsel in every case.

97. *Id.*

98. Assistant Public Defenders do represent respondents in cases regarding patients' rights, discharge hearings, and so on. But the attorneys are assigned as the cases come to the attention of the courts.

expressed wishes but congruent with the attorney's perception of what the client needs.[99]

Judges in Chicago disagree as to which of these roles is more appropriate for the attorneys to take. The dominant feeling of the courts, however, is that an attorney for the respondent should act as a strong advocate. The Illinois statute is well suited to this role for respondent's attorney: a heavy emphasis is placed on legal rights and protections; an Assistant State's Attorney presents the case for hospitalization; and hearings are held with formal adherence to rules of civil procedure and evidence.[100] The courts should continue to encourage counsel for respondents to act in the role of vigorous advocates for their clients. Since the statute establishes an adversary procedure, it is imperative that counsel act as strong advocates for their clients' stated desires. Of course, conscientious attorneys will meet with their clients and will try to assist them to understand the available alternatives and to choose the one that is best for them. But once the attorney has provided such counsel, he or she must represent the client's stated interest as effectively as possible.[101]

3. *Adequacy of Representation*

The Illinois statute specifies that counsel shall be allowed time for adequate preparation and shall not be prevented from making an investigation of the matters at issue and the relevant evidence.[102] The courts in Chicago have been adamant in requiring counsel to meet personally with clients prior to the hearings in order to prepare their cases for court. Judges encourage adequate preparation by asking counsel whether they have met with their clients regarding matters that arise before the court.

The system for providing legal assistance to respondents is one of the major strengths of the Chicago civil commitment process. Overall, the Assistant Public Defenders who provide the bulk of the representation in commitment cases are a conscientious and well-informed group, providing competent and thoughtful counsel. In addition, they are encouraged to assume the role of strong advocates. Private attorneys and mental health advocates in the Chicago area appear to believe that some Assistant Public Defenders do not advocate for their clients as strongly as they should in many cases.

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99. For a more extensive discussion of these conflicting visions of the role of counsel, see Andalman and Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal,* 45 MISS. L.J. 43 (1974); Brakel, *Legal Aid in Mental Hospitals,* 1981 A.B.F. RES. J. 23 (1981); *Preparation and Trial of a Civil Commitment Case,* 5 MENTAL DIS. L. RPTR. 201 (1981); INSTITUTE OF JUDICIAL ADMINISTRATION/AMERICAN BAR ASSOCIATION JUVENILE JUSTICE STANDARDS PROJECT, STANDARDS RELATING TO COUNSEL FOR PRIVATE PARTIES, Standard 3.1 and commentary thereto (Approved Draft, 1978).

100. *See, e.g.,* ILL. REV. STAT. ch. 91½, §§ 3-101, 3-205, 3-800-818, 6-100 (1983).

101. Equally important, the Assistant State's Attorney also must be an effective advocate for the state in cases where hospitalization appears to be necessary.

102. ILL. REV. STAT. ch. 91½, § 3-805 (1983).

To some extent, this reflects differences in individual skills and attitudes. To a greater extent, however, this may be due to the fact that Assistant Public Defenders in Chicago are clearly overworked. This is a primary weakness of this aspect of the Chicago civil commitment system. Everyone in the professional mental health and legal community concedes that there are more mental health cases than the available Assistant Public Defenders can handle. The Assistant Public Defenders meet with every civil commitment respondent without fail, but they admit that they have too many cases to be able to prepare thoroughly for the "really tough ones." The heavy load and time constraints not only make it difficult for Assistant Public Defenders to prepare for cases as well as they would wish, but also make it difficult for them to spend time with their clients to explain the legal procedures and discuss legal strategies. It is particularly difficult for public defenders to identify witnesses and make arrangements for them to be at the hearing. Of course, decreasing this workload can be done only at substantial cost. Either a greater number of Assistant Public Defenders must be hired, or additional members of the Public Defenders staff will have to be relieved of other duties so that they can work on involuntary commitment cases.

Another option, consistent with the intent of the Guardianship and Advocacy Act,[103] would be to assign state funded Guardianship and Advocacy Commission attorneys to commitment cases more frequently. Despite the fact that the Mental Health and Developmental Disabilities Code assigns primary responsibility for representing respondents in civil commitment proceedings to the Commission,[104] it is reportedly not very active in the city of Chicago. Although its staff and their work are highly regarded, like everything else connected with public mental health treatment, the Guardianship and Advocacy Commission apparently suffers from a lack of resources.

Whether greater resources are provided to the Public Defender, to the Guardianship and Advocacy Commission, or to a fund for assigning, training and compensating private counsel to represent indigent respondents, the solution to the workload problem will be difficult and costly to resolve. In the opinion of many legal and mental health professionals in Chicago, it may well be the most important improvement which can be made in the civil commitment process.

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103. *Id.* §§ 701-735. This act established the Guardianship and Advocacy Commission. The Commission contains a Legal Advocacy Service, *id.* § 703, which has two basic functions: (1) to make counsel available to persons in mental health judicial proceedings, including those relating to admission, civil commitment, competency, and discharge; and (2) to make counsel available to enforce any mental-health-related rights or duties derived from local, state, or federal laws. *Id.* § 710. The Guardianship and Advocacy Commission also contains an Office of State Guardian, which is authorized to act as a guardian for any person in the state for whom a private guardian is not available. *Id.* §§ 730-731.

104. *Id.* § 3-805.

4. Access to Information

Assistant Public Defenders report that their access to necessary information is satisfactory. This may be a fortunate circumstance of the way the system operates rather than a provision of law. The Guardianship and Advocacy Act assures access for Guardianship and Advocacy Commission attorneys to all mental health records,[105] and the statute on civil commitment provides generally that counsel shall not be prevented from making an investigation of relevant evidence.[106] Nevertheless, the Mental Health and Developmental Disabilities Confidentiality Act, if read literally, would prohibit Assistant Public Defenders from gaining access to hospital records without their clients' explicit consent.[107] Again, hospitals apparently have not restricted the attorneys' access to these records, but they probably could do so under the provisions of the Confidentiality Act if the respondent refused to authorize access for the attorney. The danger exists that some mentally ill persons, unknowingly acting against their own best interests, might refuse to authorize such access for their attorneys, and thereby place counsel and themselves at a distinct disadvantage. This danger would be alleviated by passage of an amendment to the Confidentiality Act that clearly recognized the right of an attorney representing a respondent in a civil commitment proceeding to have access to that person's hospital records.

C. The Hearing—Meeting the Criteria for Commitment

This section discusses the events surrounding a judicial hearing on the question of whether or not a person shall be committed for mental health treatment. It considers the detailed characteristics of the hearing, the various people who become involved in it, and the criteria that must be established to determine whether a person is to be committed. Note that although information in the next section is relevant to the commitment hearing, it focuses solely on the determination of the most appropriate treatment. This distinction, between determining whether or not treatment is needed, and determining the nature of treatment if it is needed, has been made primarily for analytical purposes. During the judicial hearing, consideration frequently is given to both matters simultaneously.

1. Characteristics of the Hearing

a. Time and Place

It is mandatory that every respondent facing involuntary civil commitment have a judicial hearing within five court days from the time that he or she is taken into custody or if the person is not in custody, within five court days from the filing of a petition with the court.[108] With the exception of

105. *Id.* § 712.
106. *Id.* § 3-805.
107. *Id.* §§ 804-805.
108. *Id.* §§ 3-611, 3-706.

the respondents who choose to enter a hospital on a voluntary status, a full judicial hearing is held promptly for every person against whom an involuntary civil commitment petition is filed.

Commitment hearings are held every weekday at two hospitals in the city: two days each week at Read Hospital for all respondents in hospitals on Chicago's north side and the other three days at the Illinois State Psychiatric Institute (ISPI) for respondents in hospitals on Chicago's south side. A substantial majority of respondents are hospitalized either at Read or at ISPI, which makes these sites convenient for hearings. Patients from other hospitals are transported to Read or ISPI for their hearings.[109] These procedures are a major strength of, and a feature unique to, the Chicago civil commitment system. In several of the other cities examined during the project, hearings are held only once or twice each week despite statutory requirements necessitating more frequent sessions. The weekday schedule in Chicago ensures that hearings will take place within the five-day statutory period. Additionally, the practice of holding the hearings in the major mental health care hospitals lessens the disruption of staff schedules, minimizes costs, and, most importantly, reduces the anxiety, physical discomfort and trauma for many of the respondents.

b. Presence of the Respondent

With few exceptions, the respondent is present at the hearing.[110] A violent respondent can be restrained and may be physically barred from the hearing only as a last resort. Special hearings may be held in the respondent's hospital room in cases in which the respondent is so gravely disabled that it is inadvisable for him or her to attend hearings in the normal place.[111] The routine presence of the respondent at the hearing can be considered a strength or weakness of the Chicago system, depending on one's perspective. It has been argued that respondents can suffer emotional and mental damage by listening to relatives, friends, and doctors testifying about them. Families fear that the respondent's relationship with them will suffer as a result of the courtroom experience. Examiners who are also the respondent's treating physicians believe that respondent's presence during their testimony can significantly interfere with their ability to establish a good therapeutic relation-

109. In special circumstances, hearings may be held in downtown Chicago at the Daley Center in the city's regular civil courtrooms. For example, all jury trials are held at the Daley Center rather than in hospitals. The hearing is also conducted at the Daley Center if a respondent is not being held at a hospital pending the hearing. In addition, if a particular judge begins a case at a hospital and the case is continued past the time that the judge is assigned to hear mental health cases, the hearing is scheduled for the downtown courtroom where that judge is hearing a regular schedule of cases.

110. ILL. REV. STAT. ch. 91½, § 3-806 (1983). The court is responsible for notifying the respondent, his or her attorney, and the director of the facility of the time and place of the hearing. *Id.* §§ 3-611, 3-706. Because these people are so closely involved in these cases, notification is not a problem. The court is also responsible for notifying other people designated by the respondent, and respondent's "responsible relatives." *Id.*

111. *Id.* § 3-806. In practice, the respondent's presence is almost never waived.

ship. Furthermore, the presence of the public in the courtroom can be a source of embarrassment to the respondent and may worsen his or her condition.

Alternatively, there are several advantages to having respondents present at the hearings. When respondents are present, they are able to assist in their defense to a greater extent. Also, the judge is personally able to see the respondent's condition and need not rely solely on the reports of the witnesses. Moreover, some doctors feel that the courtroom experience is frequently a useful precursor to successful treatment. First, it demonstrates to the respondent that he or she has not been confined surreptitiously by the doctor or family; the formalities of the judicial system help confirm that the confinement is an official act of the state. Second, respondents may be strongly influenced by orders or advice given to them directly by the judge. Finally, the basis for commitment is articulated during the hearing. The respondent hears about those aspects of his or her behavior that are considered unacceptable, which can be a useful starting point for shaping the respondent's behavior into more socially acceptable forms. Since the respondent's presence at the hearing may be waived by respondent's attorney and the hearing can be closed to the public, it appears that it would present substantial risk of serious harm to the respondent. The risk to the few respondents who might be harmed by being present at the hearing can be minimized without curtailing the right of respondents generally to participate in the hearing.

c. Jury Determination

Illinois is one of the few states that permits respondents to request a jury determination of whether they meet the criteria for commitment.[112] Few such jury trials occur in Chicago, however. Jury trials are considered inconvenient because they must be held downtown where jurors are available, and because they take longer due to the extra process of jury selection and the need for a more thorough presentation of evidence. Those who have experienced jury trials in commitment cases say that the jury's presence has no influence upon the final decisions because the judges would have decided the cases the same way that the juries did. For these reasons, jury trials are viewed by the legal community as a bother and delay, with no apparent benefit for the respondent. Consequently, attorneys generally advise their clients not to request a jury trial.

d. Public Access

All involuntary commitment hearings in Chicago are open to the public, and the records of court proceedings are considered to be public documents.[113] In practice, the issue of public access to the hearings is seldom raised.

112. *Id.* § 3-802.
113. *Id.* § 6-100.

Although a considerable number of people observe hearings, it is probably safe to say that most are either professionals in training (doctors, nurses, social workers, or college students) or researchers.[114] Observers from the general public are rarely in attendance.

Courtroom proceedings are generally orderly and proper. Attorneys have pointed out that courtroom decorum is extremely important in civil commitment cases because of the sensitivity of the matters being heard and the high anxiety level of the respondent and family members involved in these proceedings. Because of the sensitive nature of these proceedings, special care should be taken to ensure that the courtroom environment is quiet and orderly and that careful attention is given to witnesses as they testify.

2. *Presentation of Evidence*

Before a person is involuntarily committed, it must be shown that because of mental illness, the person reasonably can be expected to inflict serious harm on self or others in the near future or that the person is unable to provide for basic physical needs so as to avoid serious harm.[115] An exploration of specific and explicit evidence is required to establish a condition of mental illness and grounds for believing that respondent is either dangerous or substantially unable to provide for his or her own needs. Psychiatric jargon is not accepted as testimony without being explained in lay language. Conclusory statements by mental health staff or other witnesses are not accepted unless specific facts are presented to explain how such conclusions were reached.[116]

a. Role of the Assistant State's Attorney

An Assistant State's Attorney presents the case for hospitalization in every involuntary civil commitment case. The Assistant State's Attorney's presentation of the case for the hospital is a major strength of this system. Without

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114. Conceptually, the easy accessibility to court records presents a more difficult problem, particularly when otherwise confidential hospital records are introduced into evidence. Although court records are traditionally public documents, provisions have been made in some states for sealing or expunging records of courtroom procedures that may be damaging to particular individuals and are not of sufficient value to the public to justify their public availability. Because of the stigma that society attaches to mental illness and involuntary commitment, it has been suggested by some Chicagoans that court records on these matters not be open to the public in order to protect the privacy of the individuals involved. It is ironic that this problem seems to be simultaneously extremely important in concept and extremely unimportant in practice. It is highly important to the hospitals that their work remain confidential; it is equally important to the courts that their work remain public. Yet, in all the interviews we conducted in Chicago, these conflicting values and practices were never identified as a serious source of difficulty and nobody expressed concern that confidential hospital records were easily available through public court files.

115. ILL. REV. STAT. ch. 91½, § 1-119 (1983).

116. Because the Civil Practice Act applies to commitment hearings, *id.* § 6-100, the evidentiary rules applicable to other civil proceedings apply here.

117. *Id.* § 3-101.

this assistance, the judge and the hospital staff would have to assume the role of advocates rather than the more neutral roles they traditionally perform. Although some people believe it is the Assistant State's Attorney's job to represent the petitioner, the statute specifies that the State's Attorney is to represent "the people of the State."[117] Thus, the statute apparently grants the Assistant State's Attorney the discretion to pursue a case in the manner he or she determines best serves the public's interest, which may not necessarily be to advocate strongly for a respondent's hospitalization. Chicago Assistant State's Attorneys reportedly do, in fact, make a personal decision about the merits of each case and present the case at a hearing as they feel is appropriate. In most cases, of course, the Assistant State's Attorney agrees that the patient requires hospitalization and, therefore, advocates the hospital's point of view.[118]

b. Role of the Examining Psychiatrist or Clinical Psychologist

Unless the respondent waives the requirement, one psychiatrist or clinical psychologist who has personally examined the respondent must testify in person at the judicial hearing.[119] Psychiatrists and psychologists testifying in court tend to present a neutral assessment of facts and opinions related to respondents' mental conditions. Examiners do not feel comfortable advocating either for or against a respondent's hospitalization and they are not expected to take this role.

In some cases, the psychiatrist or clinical psychologist who prepared the certificate or who is actually treating the respondent testifies at the hearing. In others, the examiner represents the hospital and testifies on some or all of the cases being heard on a particular day, regardless of whether he or she is the treating or certifying examiner. For lack of a better term, the latter type of examiner can be called a "professional examiner."

The practice of employing a professional examiner has advantages and disadvantages. Observations of many commitment hearings made during the project revealed that a professional examiner usually makes a much better witness in court than the typical doctor. This type of examiner is frequently more familiar with civil commitment law, knows how to present psychiatric testimony in a manner that is useful for the court, and testifies in a particularly understandable manner. Further, the professional examiner is often

118. In the rare instance in which the petitioner has retained an attorney, the Assistant State's Attorney usually does not participate and the petitioner's attorney presents the case for commitment. The fact that the petitioner is represented by private counsel probably does not make much difference except for those cases in which the Assistant State's Attorney would decide that it would best serve the people of the state to not press hard for hospitalization.

119. ILL. REV. STAT. ch. 91½, § 3-807 (1983). The court also may appoint one or more examiners to make an additional examination of the respondent and provide a report to the court and to the attorneys for the parties. *Id.* § 3-803. With few exceptions, a single examiner testifies at a judicial hearing, because the respondent rarely waives the requirement for an examiner to testify and the court seldom appoints additional examiners.

more at ease with legal requirements such as advising a respondent of his or her rights during an examination. The professional examiner is also useful from the hospital's point of view. Doctors point out that testifying in court significantly disrupts their day, reduces the amount of time they can spend with patients, and can seriously harm a therapeutic relationship with a patient. The use of a professional examiner avoids all of these problems.

Many inexperienced examiners find the judicial hearing to be a totally alien environment and, consequently, testify in a manner that pleases neither themselves nor the attorneys. Doctors, who usually are accorded high respect and unquestioned authority in medical matters, are not accustomed to being queried about their conclusions and forced to justify the process by which those conclusions were reached. Frequently, they have had no formal training about legal procedures and do not appreciate either what is expected of them or the process through which it will be obtained.[120] Attorneys report that some examiners are hesitant to provide information and force the attorneys to "drag the facts out" through a series of probing questions. Other doctors and psychologists habitually use technical language that is not acceptable by, or understandable to, the court.

Conversely, the professional examiner's appearance in court means, in effect, that without the use of a subpoena, respondent's attorney may not be able to cross-examine psychiatrists and psychologists whose allegations are instrumental in respondent's hospitalization. Moreover, the professional examiner's testimony will, of necessity rely more heavily on written records.

Perhaps the most common problem that occurs during testimony is when the examiner is asked to assess the respondent's dangerousness. Psychiatrists, psychologists, and social workers receive no special training in predicting dangerous behaviors. Empirical studies have shown that predictions of dangerousness are notoriously poor, and are no better when done by professionals than by lay individuals.[121] Determinations of dangerousness should be based on threats or specific behaviors in which respondent has engaged in the recent past that are dangerous per se. It is possible, of course, that an examiner will be able to testify about dangerous behaviors that he or she has observed directly,[122] or will be able to testify convincingly that respondent is potentially dangerous, even in the absence of an overt threat or dangerous act. In most cases, however, the petitioner and other witnesses should be required to testify about specific dangerous behavior they have observed in respondent, and this specific behavior, not psychiatric testimony, should be the primary basis for deciding whether or not a respondent is dangerous to self or others.

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120. A short meeting with examiners who do not testify frequently prior to hearings and an orientation to the process may be of considerable benefit to everyone involved and probably could be done quickly and inexpensively.

121. *See supra* note 70.

122. It is most likely, however, that a respondent's behavior will be subdued physically or medically during the time that he or she is seen by the examiners.

It should be noted that petitioners are strongly encouraged to attend the judicial hearings as witnesses. Indeed, Chicago judges seem to be stricter about requiring the petitioner and other witnesses to be at the hearing, than those in several of the other cities observed during the study. Many hearings also will have mental health professionals (such as therapists, social workers, and nurses) in attendance to testify as needed. Nevertheless, Assistant Public Defenders reported that, in practice, an examiner will often be the only witness at a hearing.

c. Role of the Judge

In any adversary system, the arguments for and against commitment are to be presented by counsel. Judges have significant freedom to take different roles as they see fit. At one extreme, the judge can act entirely as a neutral factfinder, listening to the cases presented by the attorneys and depending upon the attorneys to establish all of the necessary facts upon which to base a decision. At the other extreme, judges can engage actively in asking questions and eliciting information from the parties in the case.

For the most part, Chicago judges believe that they serve the role of a neutral trier of facts and thus depend upon the Assistant State's Attorney and the Assistant Public Defender to establish the bases for and against commitment. Some attorneys in Chicago, however, express the opinion that Chicago judges take too active a role in the hearings, ask too many questions on their own initiative, and sometimes seem to be helping the Assistant State's Attorney make the case for hospitilization. Judges admit that they frequently solicit information that they believe is important and that has not been sufficiently established in testimony elicited by the attorneys. The extent to which judges directly examine witnesses, and whether such examination is slanted either for or against hospitalization, undoubtedly varies from judge to judge and from case to case.

From both the helping and liberty perspectives, it is advantageous that judges solicit information actively during the hearing. Occasionally, the case for or against hospitalization will be made not on the basis of the patient's needs, but on the varying abilities of the attorneys. In the interest of complete factfinding, a judge who suspects that some important information may not have been brought out during testimony should take the opportunity to question witnesses directly.

d. Role of the Respondent

In Chicago, respondents are subjected to a seemingly contradictory system of rules and procedures regarding the disclosure of information that might be harmful to their cases. The Illinois statute is one of a few that grants the respondent the right to remain silent during a psychiatric examination.[123]

123. ILL. REV. STAT. ch. 91½, § 3-208 (1983).

Psychiatric examiners are required to explain to respondents the purpose of the examination, to warn them that the information given to the examiner may be used in court, and to indicate clearly that they have the right to remain silent during the examination. If this is not done, the examiner is specifically barred from testifying in court.

Once the respondent reaches a Chicago courtroom, however, the privilege against self-incrimination seems to evaporate. Assistant Public Defenders report that the state occasionally will call a respondent to the witness stand in the hope that the respondent will "hang himself." Having failed to demonstrate convincingly that the respondent meets the statutory criteria for commitment, the Assistant State's Attorney may hope to impress upon the judge that the respondent is really in need of treatment by asking respondent to take the stand and discuss the delusions or hallucinations that form the basis of the mental illness diagnosis.

Thus, even if a respondent refused to speak with an examiner in order to avoid self-incrimination, this privilege could disintegrate in the courtroom. The Assistant State's Attorney, with a psychiatrist by his side, could call respondent to the witness stand and ask him or her a series of questions that, in essence, could serve as the basis for a psychiatric examination. The psychiatrist then could be called to the stand to testify as to his or her professional opinion about the respondent's condition.

If courtroom practice and the Illinois statute are to remain in agreement, a change in one or the other seems to be called for. Assistant Public Defenders feel strongly that their ability to represent their clients and provide effective legal counsel is seriously undermined by the state's authority to order the respondent to take the witness stand at a hearing. An amendment to the provision of the Illinois Civil Practice Act may be in order to exempt respondent in involuntary commitment cases from the general prohibition against persons refusing to testify against their own interests in civil cases.

e. Use of Records

In Chicago, as in most other cities, it is commonplace that hospital records are allowed into evidence in commitment hearings. These are records about the respondent made by attending physicians, therapists, nurses, and other ward attendants. Attorneys disapprove of the use of hospital records because such use deprives them of the opportunity to confront and cross-examine the persons who allege the information that is damaging to their clients. Hospital personnel, on the other hand, argue that enormous expense would be involved if their entire staff had to be prepared to attend hearings and serve as witnesses in virtually every civil commitment case.

In addition, information about previous psychiatric commitments and treatment is allowed into evidence at most hearings in Chicago. The Chicago legal community appears to have established an informal working principle that evidence of psychiatric history will be admissible to establish "psychiatric opinion" but not "legal fact." This seems to mean, in practice, that the

evidence may be used to form diagnoses and plan treatment strategies, but cannot be used as a sufficient basis for concluding that the respondent must be committed. According to statutory definition, eligibility for commitment must be established on the basis of recent behaviors and examinations.[124] The use of records regarding prior commitments even for these limited purposes should be closely monitored because such information can have the effect of biasing decisions in favor of involuntary hospitalization. Once previous behaviors and events have been found sufficient to satisfy the commitment criteria, the future use of the records resulting from that commitment proceeding and the subsequent treatment should be severely limited. Otherwise, a psychiatric history would make it virtually impossible for a respondent to avoid being committed again. A person should be committed only because his or her current condition warrants it.

Attorneys also indicated that judges tend to view the existence of pending criminal charges as evidence of a respondent's dangerousness. Whether or not information relating to pending criminal charges is entered into evidence during the hearing, such information probably will come to the judge's attention because it is part of the background information that the judge will have before him or her.[125] However, criminal allegations that have not yet been proven in court should not be taken as facts to support the contention that a respondent is dangerous.

3. *Continuances*

For good cause shown, continuances can be granted for periods up to fifteen days on the court's own motion or on the motion of the Assistant State's Attorney.[126] If requested by the respondent, continuances may be granted for any period of time. Continuances are fairly common in Chicago. Indeed, private attorneys and patient advocates express the opinion that too many continuances are granted. But those who are most frequently connected with the hearing—judges, Assistant State's Attorneys, and Assistant Public Defenders—do not believe that the number of continuances is unreasonable or that continuances are often granted without good reason.

Judges have several reasons for granting continuances on their own motions. Judges believe that in some situtations a respondent can receive sufficient help within fifteen days, obviating the need for commitment. By granting continuances in these situations, judges believe that they are helping such respondents because no record of involuntary commitment will be maintained. On the other hand, judges also order continuances on their own motion

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124. It should be noted that the statutorily required determination that a person is mentally ill, as distinct from a differential diagnosis used in determining the appropriate treatment, rarely necessitates information from previous psychiatric hospitalizations.

125. The admissibility into evidence of information on pending criminal charges is of greater importance, however, in the rare case in which a hearing is before a jury, who otherwise would not be aware of the pending charges.

126. ILL. REV. STAT. ch. 91½, § 3-800 (1983).

when they believe that a particular respondent ought to be committed, but witnesses who are critical to the case fail to appear in court.

The hospital occasionally asks for a continuance such as when a doctor is ill or otherwise unavailable at the time of the hearing, when the respondent has left the hospital without an authorization, or when the respondent has requested voluntary admission and the papers have not yet been completed or forwarded to the court.[127]

A respondent may request a continuance for a number of reasons also. If a respondent has contracted a physical illness, for example, the respondent's attorney may request a continuance until the patient has recovered sufficiently to be able to attend the hearing. If the respondent's attorney has been unable to communicate effectively with his or her client, the attorney may request that the court grant a continuance while he or she attempts to prepare for the case more adequately. Or, if the respondent is currently in a violent state, a continuance may be requested so that the respondent can be treated to the point where he or she can be present at a judicial hearing.

Only one practice with regard to continuances in Chicago is cause for concern. If a hospital, other than Chicago Read or ISPI, plans to request a continuance in a particular case, the hospital staff frequently does not transport the respondent to the hospital at which the hearing is scheduled to be held. The hospital requests the continuance with the expectation that it will be routinely granted. Assistant Public Defenders contend that this practice deprives them of the ability to object to a continuance on the behalf of their clients. They point out that even if their objections were effective, the hearing probably would be continued to the next week anyway because there would not be enough time that day to bring the respondent from the other hospital to the place of hearing. Hospitals should be required to transport respondents to the place of hearing in every instance, even if the hospital is requesting a continuance, unless the motion for continuance has been discussed with the respondent's counsel in advance and there is no objection.

D. Hearing—Determining Treatment

1. Presentation of a Treatment Plan

Illinois is one of a handful of states that requires a formal treatment plan—describing the respondent's problems and needs, the treatment goals, proposed treatment methods, and a projected timetable for their attainment—to be presented by the mental health facility during the judicial hearing.[128]

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127. The Assistant State's Attorney may also request a continuance if he or she feels the need to get more information to decide whether or not to object to the voluntary application.

128. ILL. REV. STAT. ch. 91½, § 3-810 (1983). The other states studied depend upon either finding the information in hospital reports submitted to the court or in having the information elicited during testimony from the examiner or treating physician. For a discussion of the other states' procedures, see *supra* site reports listed in note 6.

Implicitly it is clear that if no effective treatment can be anticipated for a respondent, the state will have failed to make its case for respondent's commitment. A related effect of requiring treatment plans is that it eliminates a problem that occurs in other systems when judges commit patients to a hospital only to have the hospital refuse admission because the respondent is not a fit case for treatment.

Mental health professionals generally are not enamored with the requirement of proposing a treatment plan at the initial hearing. They commented that a treatment plan which is based upon less than five days with a patient who may be in an acute psychiatric crisis, is likely to be highly tentative. Working within an environment in which patients have a broad right to refuse treatment, it may be difficult to say whether, when, and how specific treatment modalities will be implemented. The result in Chicago has been a pro forma conformity with the requirements of the law. Physicians and attorneys in the Chicago system agree that treatment plans submitted during initial hearings are shallow, brief, non-specific, and characterized by one person as "boilerplate." These treatment plans do not form the basis for a useful challenge to a commitment because their contents are so broad as to be virtually meaningless. In addition, an enormous amount of hospital staff time is spent in preparing treatment plans for the court, because treatment plans are prepared for all patients who go through hearings, including those who are released and whose treatment plans therefore go unused.

Despite the generally unhelpful final product that is sent to the court, people in the system are not seriously opposed to the presentation of treatment plans at the hearing and go so far as to suggest that they may, indeed, serve a purpose. The requirement of filing a treatment plan forces hospital staff to confront the question of treatment choice and the feasibility of that choice for each respondent. Courtroom discussion of treatment plans, even in generalized terms, has value in educating lawyers and judges about the types of treatment that are available in the hospitals, the time periods in which treatments might be effective, and the nature of "cures" that may be expected from these treatment modalities.

The value of treatment plans would be significantly enhanced if they were more specific about the respondent's condition and discussed alternative treatment modalities. In order to make such greater detail possible without further infringing on hospital staff time, consideration should be given to preparing treatment plans only for those respondents found eligible for commitment.

2. *Treatment Options and the Less Restrictive Alternatives Doctrine*

Virtually any mental health facility or hospital with a mental health unit that is willing to accept a respondent on order of the court is statutorily deemed an appropriate placement site.[129] Most of the judicial commitments

129. *Id.* § 3-811.

are to public hospitals. Nevertheless, a statutory preference is expressed for treatment in the least restrictive alternative.[130]

In civil commitment hearings, the least restrictive alternatives doctrine can be applied in two different ways. One application treats the doctrine as a threshold issue: Is there a way to administer treatment in a setting that is less restrictive than inpatient hospitalization? If the answer to this question is yes, then a respondent's case is dismissed and no commitment is ordered. The second application is to consider the doctrine in the context of a commitment alternative: Given that a person meets the statutory criteria for commitment, what is the least restrictive manner by which treatment can be provided? Although the Illinois statute requires the second application of the less restrictive alternatives doctrine,[131] in practice, judges also employ the first application of the doctrine and may dismiss a respondent's case if evidence reveals that a viable outpatient alternative is available.

The question of least restrictive alternatives is raised invariably at every hearing, frequently in a pro forma manner and rarely with thoughtful, careful consideration. Most often, it arises in response to a question by the Assistant State's Attorney to the hospital examiner as to whether less restrictive alternatives were considered for the respondent and whether such alternatives are appropriate. Hospital staff usually respond that less restrictive alternatives have been considered and are inappropriate, without providing any detail about what specific nonhospital placements had been explored and the reasons they were ruled out. Most frequently, the reasoning for this decision as expressed in testimony does not flow from an analysis of existing alternatives but from an examiner's opinion that a person must be hospitalized, thereby rendering discussion of other alternatives irrelevant.

The nature of Chicago's mental health system, at least in part, explains both why less restrictive alternatives are not often considered extensively during commitment hearings, and why caution is needed to be sure that they are considered. Because of the effective network of outpatient clinics in Chicago, people who might benefit from treatment alternatives that are less restrictive than inpatient hospitalization are likely to receive treatment from the CMHCs. Thus, most people who reach judicial hearings in Chicago are seriously ill and need inpatient care. For most hearings, then, it probably is safe to assume that less restrictive alternatives are inappropriate and that a careful investigation of placement options, even though statutorily required, is not a useful expenditure of personnel resources. The inherent danger of this situation is that a presumption will be made that, because the system works as it does, and because the respondent has reached this stage of the process, the respondent must be seriously ill and in need of hospitalization. The purpose of the hearing is to establish whether or not hospitalization

130. *Id.*
131. *Id.*

is necessary, yet the Chicago system practically invites that conclusion as a presumption.

Assistant Public Defenders in Chicago express the opinion that more attention could be given to community-based less restrictive alternatives than is given in most cases. Although the responsibility to consider treatment options is fixed by statute on the mental health facility's director,[132] respondent and respondent's attorney have a greater interest in considering alternative resources. The Assistant Public Defenders make an effort to determine whether or not an alternative would be appropriate in a particular case, but they are severely constrained in this effort by their taxing caseload. These attorneys suggest that a small staff of social workers should be specifically designated to do a careful investigation of the alternatives to hospitalization available to respondents in mental health cases. Organizationally, this staff could be located in the Department of Mental Health and Developmental Disablities, the Guardianship and Advocacy Commission, or the court.[133]

Currently, neither hospital mental health staff nor judges and attorneys have extensive knowledge of community-based facilities. Both the mental health and the legal communities involved in involuntary commitment need to be better informed about the resources available in Chicago and to have access to updated information about the capacity of community programs to accept new cases. A heightened awareness by judges and attorneys of the types of treatment programs available in the Chicago area, the way these programs function, and the types of people who are eligible to receive their services, would help implement the statutory intent to utilize less restrictive alternatives.

One way of facilitating such an awareness would be to establish a system whereby current information about community-based, less restrictive treatment alternatives and their capacity to accept new cases is readily accessible. Community treatment facilities handle an enormous caseload and are currently experiencing a decrease in funding from government sources. Thus, it is important to know not only that a less restrictive treatment facility exists, but also whether it has the capacity to accept new treatment cases. Liaison to these agencies might be established through the Guardianship and Advocacy Commission, the Department of Mental Health and Developmental Disablities, or through the court staff.

Another problem that has bothered judges and community-based treatment staff about commitment to less restrictive alternatives is the lack of any enforcement mechanism. If a respondent is committed to attend treat-

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132. *Id.* § 3-810.

133. As discussed earlier, some of the burden of exploring less restrictive alternatives could be relieved if the effort was limited to those respondents actually found eligible for commitment rather than for all respondents. Background information about a respondent still could, and should, be compiled prior to a hearing; but a detailed investigation of community treatment resources would be done only if it was determined that the respondent was in need of them.

ment sessions or take medications, the statute provides no method to enforce this plan.[134] The lack of an enforcement mechanism has made many judges reluctant to commit a respondent to a community-based facility and has made such facilities hesitant to accept a patient who is under a commitment order. Consideration should be given to a statutory change to put enforcement power behind commitments to less restrictive alternatives.[135]

Of course the limited reliance on the use of community-based alternatives to hospitalization is not solely due to problems in the civil commitment process. Community-based programs are hard to establish and seem to be decreasing in number. The general public does not respond well to having "mental cases" walking the streets or, worse yet, living in the house next door. For these as well as budgetary reasons, structured residential facilities are in short supply, not only in Chicago but in many major cities.

3. *Judicial Specification of Treatment Modalities*

Judicial orders of commitment only place the respondent into the care of a person or an institution. Judges have not attempted to write orders that specify treatment modalities or restraints for the institution. Consequently, institutions have retained full discretion over the manner in which the patient is to be treated once he or she is sent to the institution. While this practice is widely considered appropriate—essentially leaving the commitment to the judge and the treatment to the doctors—a judicial order regarding specific treatment that conforms with the treatment plan submitted by the hospital is not out of the question.

Moreover, members of the legal community often overlook the fact that the concept of the least restrictive alternative can be applied within a hospital setting as well as to community-based outpatient resources. Hospitals have a variety of treatment programs and alternatives that vary in restrictiveness: home visiting privileges, grounds privileges, open wards, locked wards, and seclusion rooms. Traditionally, the hospital has been viewed as a unitary treatment option that a judge might order. The Illinois statute, however, authorizes the court to order the least restrictive alternative for treatment that is appropriate for the respondent[136] and there is no apparent reason why it would be inappropriate for the court to order the least restrictive alternative within a hospital setting. It would appear that courts can, in most instances, rule on the allowable level of restrictions which may be imposed

134. ILL. REV. STAT. ch. 91½, §§ 3-811, 3-812 (1983). If a patient fails to comply with a court order for community-based treatment, the court may modify its order and place the patient in another form of treatment, but the court cannot force the patient to attend the community-based treatment sessions. *Id.* § 3-812.

135. For example, the statute could be amended to require that a hearing be held to order a new less restrictive alternative or hospitalization for the remainder of the authorized commitment period, if evidence is presented that a less restrictive treatment alternative is failing to meet the person's needs, either because of the person's lack of cooperation or a deficiency in the treatment modality.

136. ILL. REV. STAT. ch. 91½, § 3-811 (1983).

on patients without usurping the treatment authority of mental health professionals.

4. *Voluntary Outpatient Treatment*

The Chicago legal community has devised an informal process that has come to be called "voluntary outpatient treatment." The process has no formal legal basis and is purely independent of any statutory prescription. The process is invoked cooperatively by the judge, the Assistant States's Attorney, and the Assistant Public Defender for people whom they consider to be "borderline," i.e., people who seem to need some help but are not ill enough to meet the statutory criteria of "subject to involuntary admission." To invoke the process, the Assistant Public Defender informs the judge at the hearing that the respondent would like to receive voluntary outpatient treatment. If the judge agrees, the case is not dismissed, but the person is not committed. Instead, the respondent agrees to enter an outpatient treatment facility and report back to the court after ninety days. A request is made for a ninety-day progress report from the treatment staff at the outpatient facility. If good progress is made, the case will be dismissed after the ninety-day period. If no progress has been made and the respondent's condition seems to warrant it, the commitment process is reinitiated at the discretion of the petitioner. Judges and attorneys have had much success with voluntary outpatient treatment. Although they admit candidly that its legal standing is completely uncertain, the informal arrangement has not been challenged.

E. Posthearing Matters

1. Monitoring Treatment and Patient Progress

The treatment plan considered during the commitment hearing must be revised and filed with the court no more than thirty days after a respondent has been involuntarily committed. The court is to review this document to determine whether "the patient is benefitting from treatment" and has the authority to discharge the patient or to rehear the case if it is not satisfied with the report.[137] In practice, although hospitals regularly file the thirty-day plans with the court, judges almost never review them.[138] Mental health professionals and attorneys agree that the requirement to file a thirty-day plan is a good one, but only if the plans are reviewed, rather than filed away. The appropriate person to review these plans may be the respondent's

137. *Id.* § 3-814.

138. The treatment plan and reporting requirements specified by statute apply equally to community-based, less restrictive treatment alternatives. Chicago judges report little success, however, in receiving progress reports from staff in these facilities. This may be another reason why judges are hesitant to use less restrictive treatment alternatives. Some mechanism should be established to provide information to the court about a patient's progress in, and the services offered by, a community treatment program.

attorney. Although Assistant Public Defenders assigned to mental health cases are already overburdened, the review of thirty-day plans would not constitute a major increase in their workload because only a small fraction of their clients remain in treatment long enough for a thirty-day plan to be prepared. Thus, only a handful of plans would have to be reviewed each month.

The staff at treatment facilities are required to review and update treatment plans at least every thirty days after the initial revision, but need not file such revisions with the court except in connection with a hearing. This guarantees that each patient's case receives continual attention, at least on a monthly basis. Furthermore, to the extent that patients and their families participate in the preparation of treatment plans, patients are less likely to resist treatment and, therefore, more likely to benefit from it.

2. *Respondent's Right to Refuse Treatment*

The issue of a patient's public right to refuse treatment following commitment is one of the most difficult issues in mental health law. Involuntary commitment in no way presumes that a patient lacks the capacity to make decisions about treatment.[139] Questions of competency or capacity to make treatment decisions are not raised during civil commitment hearings and, if raised at all, must be taken up in separate guardianship proceedings. Contemporary law and practice have firmly fixed the principle that patients may not be held in custody without receiving treatment.[140] Yet, if a patient is allowed to refuse all treatment, the institution's only options are to discharge the patient or to hold him or her without treatment. Inpatient treatment centers around Chicago reportedly honor the patient's right to refuse treatment.[141] Private institutions, which are populated almost exclusively by voluntary patients, will discharge patients who refuse to accept treatment rather than force the treatment upon them. Public hospitals will honor the patient's right to refuse a particular treatment and will work with the patient in an attempt to offer treatment in other modalities that the patient finds more acceptable. If a patient in a Chicago public hospital refuses treatment of any variety, the hospital frequently will attempt to transfer the patient elsewhere or may release the patient rather than continue to hold him or her without providing any form of treatment. Outpatient treatment facilities depend primarily upon their patients' voluntary desire for treatment. The patient's right to refuse treatment in outpatient facilities is practically absolute; if the patient does not want treatment, he or she simply stops attending the treatment facility.

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139. ILL. REV. STAT. ch. 91½, § 2-101 (1983).

140. *See, e.g.*, O'Connor v. Donaldson, 493 F.2d 507 (5th Cir. 1974) (persons involuntarily committed under the rationale that they are in need of treatment have a due process right to treatment), *rev'd on other grounds*, 422 U.S. 563 (1975).

141. ILL. REV. STAT. ch. 91½, § 2-107 (1983). The statute provides, however, that a patient may not refuse services which are necessary to prevent the infliction of serious harm by the patient on himself or others. *Id.*

Some doctors believe that the statute is interpreted too strictly in Illinois. They point out that the right to refuse treatment is to be honored unless treatment is "necessary to prevent the recipient from causing serious harm to himself or others."[142] Because in other sections of the statute this type of exception is expressed as "physical harm,"[143] the omission of the word "physical" seems to indicate that other types of harm, such as emotional and mental harm, may justify the administration of treatment over the patient's objection. Others point out the ethical bind in which the right to refuse treatment places mental health professionals. For example, if a depressed patient refuses treatment that would relieve the depression, and if the refusal is seen as a manifestation of the illness, does a professional service provider have a responsibility to try to convince the patient to accept it? The line between friendly persuasion and authoritarian coercion is hard to define. On the other hand, this right coupled with the limitations over the more intrusive forms of therapy such as the use of physical restraints, isolation, and electroconvulsive shock, substantially protects the patient against some of the abuses that have occurred elsewhere.[144]

IV. CONCLUSION

The civil commitment process in Chicago has a number of major strengths, and some significant weaknesses. From a legal perspective, the outstanding feature is the legal rights afforded the respondent and the measures taken to protect those rights. By statute, hospital policy, Department of Mental Health and Developmental Disabilities administrative rule, and the everyday practices of counsel, an extraordinary concern is shown for the legal rights of all respondents involved in this process. The Illinois statute and the implementation of this law in Chicago stand among the best in safeguarding patients and litigants. In addition, there are the routine provision of counsel, and the procedures and practices designed to prevent a respondent from becoming lost in the system. Finally, throughout the process, there is the emphasis on using the least restrictive alternative and the least drastic means available to assist a respondent. The primary weaknesses of this civil commitment process include: the absence of a requirement for direct testimony or for evidence of an overt act or threat demonstrating that a respondent is dangerous; the overreliance on psychiatric records during the hearing; the lack of legal mechanisms for ensuring that a respondent is complying with an order of commitment to a community-based program; and the inadequate number of resources available to counsel for indigent patients and respondents.

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142. *Id.*

143. *See, e.g., id.* §§ 2-108, 2-109. It is interesting to note that the text proposed for § 2-107 in the Governor's Commission Report included the adjective "physical." Governor's Comm'n Report, *supra* note 1, at 27.

144. For a more extensive discussion of this point, see Governor's Comm'n Report, *supra* note 1, at 30.

From a treatment perspective, the major strength of the Chicago system is its network of Community Mental Health Centers. The array of prevention, treatment, and aftercare services provided by the CMHCs help to relieve the pressure for commitment and assist a great number of Chicagoans to cope with their problems while avoiding deeper penetration into the mental health system. Some beneficial aspects of the civil commitment process itself are the opportunities for prompt treatment, the easy availability of noncoercive treatment status through a voluntary admission, and the practice of holding hearings at the two major hospitals accepting involuntary admissions. Problems in the treatment area include the shortage of community-based residential facilities for mentally ill persons and the lack of information about those that do exist, the absence of additional background information on respondents, the paperwork created by the stringent legal requirements, and a patient's right to refuse treatment.

The report developed on the basis of the examination of the Chicago civil commitment system offered a comprehensive set of recommendations addressing the weaknesses discussed above as well as other areas in which practices and formal procedures could be improved. These recommendations can be found in the appendix to this article. Although the recommendations reflect both the "liberty" and the "helping" attitudes, we recognize that others will strike a different balance and that the implementation of some of these suggestions will require the allocation or reallocation of scarce public resources. Nevertheless, we urge their consideration for making a good civil commitment system even better at providing assistance and protection to all Chicagoans.

APPENDIX

In addition to presenting a descriptive analysis of Chicago's system of law relating to the mentally ill, it is imperative that practical lessons be extracted from this work. These lessons are presented in the form of recommendations, which were derived from several sources. Many of the recommendations presented here were made by people involved with the Chicago system. Others were made with reference to similar situations by people at the other research sites. Some recommendations spring primarily from the research staff's observations of civil commitment procedures and their review of the professional literature on this topic.

After reviewing the list, some readers may be surprised that certain recommendations have not been made. There are many issues in Chicago on which recommendations might have been offered, but were not for two reasons. First, if the Chicago system is administering a certain procedure in a manner that appears impossible to improve upon, no recommendation was made. Second, in some situations the countervailing factors are so nearly balanced that any recommendation would be hard to justify. We preferred to make no recommendation rather than to present one with a weak foundation.

The proffered recommendations are not one-dimensional. Most of them

relate simultaneously to several substantive areas of concern. They have been grouped according to what appears to be the most important focus of each recommendation, although we are well aware that recommendations affect other aspects of the system as well. Similarly, the implementation of some recommendations will obviate or mitigate the need for others. For the sake of simplicity and brevity, however, the recommendations have been presented in a unidimensional list.

Finally, although all the recommendations are important, some are of greater urgency than others. A three level rating system has been used. Recommendations preceded by three asterisks(***) are the most critical; those preceded by one asterisk (*) are the least urgent; and those with two asterisks (**) some where in between.

Several factors went into the ratings. First, the theoretical importance of each was considered from the points of view of the law, mental health treatment, and general importance to society. Second, thought was given to the likelihood that the recommendation could be implemented, based upon considerations of cost and procedural difficulties. If a recommendation was both theoretically important and easy to implement, it was assigned three asterisks; if theoretically unimportant and hard to implement, it was given one asterisk (if made at all). Other recommendations were rated in consideration of the trade-off between importance and difficulty.

It would be surprising, indeed, if everyone agreed on the ratings assigned to the recommendations. What may be an important recommendation to one person may be not only unimportant but also objectionable, to another. Many points of view were considered in both writing and rating the recommendations. Final responsibility for deciding how the recommendations appear in this article lies with the authors. But final responsibility for how the recommendations will be implemented rests with the people of the City of Chicago.

RECOMMENDATIONS

A. RELATING TO VOLUNTARY ADMISSIONS

(**) The court should meet with state hospital administrators to review their reasons for their use of voluntary rather than informal admissions, and the court should not interfere with this practice unless it clearly can be shown not to be in the best interests of society and respondents.

(***) Some means should be established to expedite significantly the appeal process after the rejection of a patient's application for voluntary admission to a hospital for mental health services.

(**) Once an involuntary commitment proceeding has been initiated and the respondent has requested voluntary admission, if the court has any question about whether voluntary admission is appropriate or needed, it should require the filing of a second certificate of examination. If two certificates already have been filed, the court should exercise its authority to require another, independent examination.

(*) After an involuntary commitment has been initiated, a respondent who

is considering voluntary admission should be given more complete information about what he or she is "buying"; counsel should certify to the court that such information has been given to the patient before the court accepts the voluntary application.

B. RELATING TO RESPONDENT AND PATIENT RIGHTS

(***) Written information given to respondents regarding their legal rights and protections should be rewritten in simpler language.

(*) Time and care should be taken to speak personally with every respondent in order to explain clearly the respondent's legal rights and protections, and the treatment and commitment process. Prior to doing so, respondent should be asked whether he or she wishes to engage in this conversation, so that this verbal explanation of rights can be waived at respondent's request.

(*) The certificate of examination should be changed to indicate clearly whether or not the examiner disclosed the respondent's right to remain silent during the examination as required by the statute.

(**) A procedure should be devised by which an independent examiner can be appointed quickly and inexpensively, such examiner to be independent of the Department of Mental Health and Developmental Disabilities and to be available for examinations and presentation of results within a short period of time.

(**) The mental health code should be amended to specify that a respondent has both the right to testify and the right to refuse to testify at his or her hearing. Alternatively, the Illinois Civil Practice Act should be amended to specify that the respondent in a civil commitment hearing shall not be compelled to testify.

(**) All involuntarily committed patients should have guaranteed access to a telephone and should be provided with a reasonable sum of money upon request if such telephones are pay telephones.

C. RELATING TO EVENTS AT THE HEARING

(***) Examiners who prepare certificates should be required to report what psychiatric records they studied and which other examiners they consulted before examining respondent and preparing the certificate. They should indicate, if possible, which of their conclusions depend substantially on their own observations and which primarily echo or reinforce prior conclusions made by others.

(*) Respondents who can afford to reimburse the state for the expenses of providing a public defender should be required to do so, or should be encouraged to retain private counsel.

(**) Respondents should be required to be brought to every hearing, even if a continuance is to be requested by the hospital.

(***) It should be required that at the time of a judicial hearing, the court should be informed of the complete history of medication that was provided to the patient during the prehearing period, and the probable effect that such medication currently has on the respondent and his or her ability to assist counsel and to testify in court.

(*) Judges should further emphasize courtroom order and decorum.

D. RELATING TO MATTERS OF EVIDENCE

(**) The court should encourage that specific overt acts or threats be recorded on mental health petitions whenever possible in support of the allegation that a person is dangerous to self or others or is unable to care for his or her basic physical needs.

(***) Examining psychiatrists should provide, at a minimum, a full standard mental status examination report as part of the medical certification.

(**) Information on previous psychiatric treatment should be admissible into evidence at the commitment hearing for purposes of diagnosis and treatment planning, but should not be accepted as sufficient evidence that respondent meets the criteria for commitment.

(**) Judges should not seek primary information about dangerousness from examiners. Rather, dangerousness should be inferred from specific threats or overt acts of respondent, reported in testimony given by petitioner and other witnesses.

(**) At recertification commitment hearings, following 60-day or 180-day commitment periods, a review of periodic treatment plans from throughout the treatment period should be required as evidence that treatment has been presented as planned and has been effective.

E. RELATING TO LESS RESTRICTIVE ALTERNATIVES

(**) Prior to the judicial hearing, the mental health facility should be required to make an investigation of respondent's social and family situation and provide the findings to the judge.

(**) More attention should be given to less restrictive treatment alternatives during judicial hearings.

(**) Judges and attorneys should become more aware of community-based treatment programs that are available as less restrictive alternatives.

(*) A system should be established so that current information is readily accessible about community-based, less restrictive treatment alternatives and their capacity to accept new cases.

(***) In spite of all the difficulties of presenting treatment plans within the first five days of treatment, treatment plans presented to the courts during commitment hearings should be as specific as possible regarding respondent's condition and should discuss the possibility of less restrictive treatment alternatives within the hospital.

(**) Consideration should be given to a practice whereby detailed treatment plans and considerations of less restrictive alternatives be undertaken only for patients who are committed.

(**) Liaison should be established between the court and any community outpatient facility to which a respondent is committed in order to provide feedback to the court about the patient's treatment progress.

(**) Consideration should be given to a statutory change to put enforcement power into commitments to a less restrictive alternative.

F. RELATING TO PROFESSIONAL DUTIES AND RESPONSIBILITIES

(**) Doctors who are to examine respondents and prepare medical certifications should be required to display a minimal fluency in oral and written English.

(***) The court should continue to encourage public defenders and other appointed counsel to act in the role of vigorous advocates for their clients.

(***) Ways should be identified to lighten the workload of the public defenders.

(*) The Mental Health and Developmental Disabilities Confidentiality Act should be amended so that counsel representing civil commitment respondents are guaranteed free access to all relevant hospital records.

(***) Careful consideration should be given to the feasibility of increasing the staff and extending the activities of the Guardianship and Advocacy Commission in the Chicago area by having Commission staff act as (1) liaison to community outpatient facilities, (2) patient advocates, and (3) guardians ad litem.

G. RELATING TO CARE AND TREATMENT

(***) A copy of the 30-day treatment plan, which is filed with the court, should be provided to and reviewed by the respondent's attorney.

(*) Procedures should be explored to facilitate the legal process of appointing guardians for respondents who are not able to provide for their basic physical needs.

(*) The court and community care-providers should explore possible sources of people who could be appointed legal guardians to respondents who are not able to provide for their basic physical needs.

(**) Administrators of the city mental health clinics and state hospitals should develop and implement a more cooperative procedure for referring patients from the city clinics to the state hospitals, in order to effect a significantly lower rate of admissions refusals.

(***) All community mental health centers that have not already done so should establish effective ongoing liaison with state hospitals to facilitate referral of all cases in their catchment area that are denied voluntary admission by the hospital and all patients who are discharged from the hospital and would benefit from transitional support services.

(***) Upon request for information about a patient, hospital staff should not automatically refuse to provide the information; rather, staff should immediately check with the patient and inquire as to whether or not the patient wishes to authorize release of the requested information.

H. RELATING TO EDUCATION AND TRAINING

(**) A formalized training program should be established for the Chicago police on the nature of mental health disorders, how to communicate with and handle mentally disordered people, and community resources to which mentally ill individuals may be taken.

(***) An orientation should be given to inexperienced examiners who are going to testify at a hearing, prior to the time that the hearing begins.

(**) Court and state hospital officials should arrange for the preparation of a set of standard orientation materials to be used by legal and mental health professionals who become involved with civil commitment in Chicago.

(**) Court and mental health professionals should arrange for periodic, continuing education seminars in the Chicago area to keep people who work in this system up to date on relevant developments in law, medicine, and society.