Changes in North Carolina Civil Commitment Statutes: The Impact of Attorneys

ROBERT D. MILLER, MD, PHD
PAUL B. FIDDLEMAN, PHD

Although authorized by statutes, involuntary civil commitment in this country was largely a clinical process until the 1960s. Patients were hospitalized on the statements of one or two physicians, without advice of counsel, opportunities to defend themselves in hearings, or any legal recourse save habeus corpus writs, which were seldom used and even less frequently successful.[1,2] When courts began to take an interest in commitment, they required due process protections for persons subject to commitment.[3–7] Civil libertarians argued that lack of adequate legal representation and the nearly complete concurrence between physician recommendations and commitment hearing outcomes demonstrated a usurpation of judicial authority by psychiatrists.[2,8–11] As a result, requirements for effective counsel for patients were enacted in a number of states;[12] in those jurisdictions in which the statutes were taken seriously, concurrence rates with physician recommendations (and commitment rates) dropped significantly.[13–20] While some authors saw this outcome as desirable,[13–15] others pointed out that high concurrence rates do not automatically reflect undue judicial deference to psychiatrists.[20,21]

By contrast to the prevailing legal view that psychiatric authority is so great that providing attorneys for patients but not for the other side in commitment hearings will create an adequate balance,[22,23] the sharp drop in commitments was viewed by clinicians as evidence that psychiatric power evaporated in a legal setting when opposed by active adversarial counsel, and that the system had become unbalanced in the opposite direction.[23–27]

North Carolina experienced this drop in commitments (up to 90 percent in one area) after the introduction of full-time patient attorneys at the four state mental hospitals (treating over 80 percent of the state's committed patients) in 1977. In reaction, a task force of the N.C. Division of Mental Health, Mental Retardation, and Substance Abuse Services (DMH) on which one of us (RM) served—and which included clinicians, patient attorneys, and Attorney General's staff—recommended several changes in the

Dr. Miller is Director of Forensic Training, Mendota Health Institute, 301 Troy Dr., Madison, WI 53704; Clinical Associate Professor of Psychiatry and Lecturer in Law, University of Wisconsin-Madison (608-244-2411 x392). Address correspondence to Dr. Miller.

Dr. Fiddleman is Staff Psychologist, John Umstead Hospital, Butner, North Carolina 27509; and Associate Professor of Psychology, University of North Carolina, Chapel Hill, NC 27514.

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commitment statutes that were adopted by the General Assembly:

1. The definition of dangerousness was slightly broadened, removing the qualifier "imminently" and including patients whose impaired judgment, self-control, or discretion would lead to serious physical deterioration.

2. Specific procedures were adopted to implement outpatient commitment as an alternative to inpatient commitment.

3. Full-time Associate Attorney General (AAG) positions were created at the four state hospitals to represent the state's interests and to provide a counterbalance to the previously legally unopposed patient attorneys. These AAG's were the first attorneys in the country whose positions were established by the state solely to represent petitioners and hospital staff at commitment hearings. We undertook this study to determine the effects of such attorneys on the results of commitment hearings, and to evaluate this pilot program for the benefit of other states that might wish to follow North Carolina's example.

Methods

The court files for all adult patients who had initial commitment hearings at John Umstead Hospital during periods six months before and after the statutory changes went into effect on October 1, 1979 were examined for these data: (1) Type of admission—mental or inebriate. (2) Most recent physician's recommendation prior to the hearing. (3) Court disposition—release, commitment to outpatient treatment, or commitment to inpatient treatment.

Data on total admissions to John Umstead Hospital during the study periods were obtained from the DMH. All physicians who were treating committed patients during the study periods were sent questionnaires concerning their knowledge of and attitudes toward involuntary commitment procedures and the statutory changes; and interviews were held with all attorneys and judges involved in hearings during the study periods.

Results

During the two periods under investigation (March 1-August 31, 1979; and October 1, 1979-March 31, 1980), 914 mental patients and 821 inebriates were admitted involuntarily to John Umstead. Table 1 indicates the physician recommendations for all involuntarily admitted patients during the study periods. Tables 2 and 3 show the percentage agreement between those recommendations and the final court dispositions. Since the number of outpatient commitment recommendations and disposition was too small for statistical significance, these data were combined in the following manner: for recommendations for inpatient commitment, outpatient commitments were treated as releases; and for recommendations for release, outpatient commitments were treated as commitments for statistical purposes. These groupings did not affect the results significantly.

Table 1. Physician Recommendations to the Court for Disposition.

Mental Patients

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

*Not statistically significant, X^2

Inebriates

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

†$p = 0.030$, X^2 ‡$p = 0.003$, X^2

Table 2. Court Concurrence with Physician Recommendations—Mental Patients.

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

*$p = 0.001$, X^2

Table 3. Court Concurrence with Physician Recommendations—Inebriates.

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

†$p = 0.113$, X^2 ‡$p = 0.129$, X^2

There were no statistically significant differences in the patterns of recommendations for mental patients between the two study periods; but there were significantly more recommendations for both inpatient and outpatient commitment for inebriates after the changes. The differences in concurrence rates of disposition with physician recommendations for mental patients between the two study periods were highly significant. The differences for inebriates were in the same directions (higher concurrence for commitment, lower for release), but did not reach statistical significance.

Discussion

Since inebriates without other major psychiatric disorders are offered only detoxification at North Carolina state hospitals (with treatment for alcoholism available at Alcohol Rehabilitation Centers), their admissions are brief, and physicians recommend release for the vast majority by the time of the hearing (held within 10 days of admission). There are few contested hearings and little community pressure to keep inebriates beyond the detoxification period. It is therefore not surprising that for inebriates there were no statistically significant differences between the two study periods.

There were two very significant changes in concurrence for mental patients from one study period to the other: Court agreement with physician recommendations for commitment went up; and Agreement with recommendations for release went down. To determine possible causes for these changes, we will examine each of the participants in the commitment process.

Patients There were no significant differences between the periods in the total number of patients admitted to the hospital involuntarily.[28] John Umstead, like many state hospitals, serves a population of chronically ill patients who have multiple admissions; 68 percent of patients admitted during the study periods were readmissions.[29] And as can be seen from Table 1, the physicians' recommendations nor mental patients for the two periods were virtually identical, another indication that there were no differences in the patient population between the two periods.

Physicians There was only one new psychiatrist (out of 37) on the hospital staff. Of the 21 who could be contacted of those who had been on the staff during the study periods, 16 (76 percent) responded. Of those, 10 said they had not changed their recommendations to the court in any way between the two study periods; three said they were recommending more commitments, and two said they were recommending fewer. Table 1 shows the effect of these changes was no difference in the overall pattern of recommendation between the two periods. Therefore, it is unlikely that physicians contributed to the differences between the study periods.

Judges The same four judges heard all the hearings during both study periods. Interviews with each revealed their basic attitudes and legal

philosophies had not changed; all believed physicians' recommendations should almost always be followed. They explained the differences in their decisions between the two periods on the basis of the activity (or lack of it) on the part of the attorneys; this point will be discussed further below.

Changes in definition of "dangerousness" Although the addition of impaired judgment, self-control, or judgment as criteria for dangerousness was originally predicted by the drafters of the DMH Task Force report to make it easier to commit patients, in practice this was not the case for several reasons. First, the definition of dangerousness rarely came up in court after the new statutes became effective in October of 1979. (This statement is borne out in conversations with all judges and attorneys who were involved in the second study period, plus personal observations by the authors in the hearings.) Second, the revised statute also required that the alleged impairment lead to a "reasonable probability of serious physical debilitation... within the near future,"[30] language that in effect made the criteria equally strict as they had been previously. This interpretation was upheld by the N.C. Court of Appeals[31] and therefore the changes in language had little bearing on the disposition of cases.

Attorneys Since it appears the changes cannot be explained by the impact of the patients, physicians, judges, or changes in definitions, the only remaining source of variation is the attorneys. Two major changes occurred on October 1, 1979, and we believe each had significant impact on the court's disposition of cases.

Prior to October 1, patients were represented by a full-time attorney who was a zealous civil libertarian and saw her role as involving winning release for all her clients (even if they wanted to stay in the hospital!). She was opposed by a part-time attorney for the state who had no time to prepare cases, was not particularly knowledgeable in mental health law, was quite passive in court, and seldom called any witnesses. As a result, when physicians recommended release for patients, there was seldom anyone to oppose release, and the high concurrence for release was observed.

In the case of commitment recommendations, however, the patient attorney raised numerous procedural objections, often to technicalities concerning how the various forms involved in the commitment process were executed. Since no one had ever challeged these procedures before, technical violations had been allowed to exist for years (such as boxes left unchecked, inadequate documentation of evidence or conclusory statements). The passive state's attorney had neither the time to rectify the errors prior to court nor the knowledge to challenge the patient attorney's objections; as a result, the judges were forced to release a number of patients despite strong recommendations for commitment by physicians.

On October 1, 1979, both attorneys resigned (for reasons unrelated to the statutory changes); the new patient attorney saw her role (still undefined by N.C. statute except to "represent the patients") as acting in the best interests of her clients, even if that meant she would not represent their

expressed wishes to the court, or not effectively challenge evidence and testimony that was in favor of what she believed best for her clients. The new full-time AAG was both knowledgeable in mental health law and had sufficient time to prepare cases fully by contacting not only the hospital physician but also the petitioners and other interested parties in the patient's community. During his tenure, the number of community witnesses who testified in court increased dramatically. According to conversations with both attorneys and limited personal observations (a prospective study to investigate specifically the role of lay witnesses is currently under way), the majority of these witnesses testified in favor of commitment. This bias was introduced by the fact that the AAG would advise lay witnesses to testify only when it appeared their testimony would have significant impact on the outcome of the hearing. If both the physician and the petitioner favored release, there was seldom any lay witness testimony; but if the petitioner favored commitment, and especially if the physician was recommending release (which the AAG would determine prior to contacting the petitioner) the petitioner and other interested parties would be advised to come to the hearing and testify. With a relatively passive patient attorney who raised no procedural objections and relatively few substantive objections, the bias of the court swung toward favoring commitment, even when the physician recommended release, particularly as physicians rarely testified in person. (They were seldom called by either attorney, and when they were asked to come, they raised so many objections that the attorneys stopped requesting that they come.) Therefore, physician recommendations for commitment went largely unopposed by the patient attorney, were usually supported by the AAG and (if necessary) lay witnesses, leading to the observed increase in concurrence rates for such recommendations. Conversely, recommendations for release were not used forcefully by the patient attorney (as they had by her predecessor) and were often discounted as well by the AAG during his presentation of lay witness testimony in favor of commitment; therefore, it is not surprising that concurrence for release recommendations decreased.

Conclusions

Others have well documented the results of introducing activist patient attorneys into a previously paternalistic, physician-dominated system of civil commitment—a dramatic drop in commitment rates. Our study certainly supports this observation; prior to the advent of full-time patient attorneys in 1977, concurrence rates for all physician recommendations had been nearly 100 percent.[19] The reactions of most clinicians and some attorneys has been to argue that a true adversary system (if one is to be imposed) should involve trained attorneys on both sides, not an attorney opposed only by a legally unsophisticated physician whose job is to treat patients not to prepare legal briefs and rectify procedural errors arising even before hospitalization occurs.[26,27]

The results of North Carolina's experiment with attempts at such a balanced system do demonstrate that the addition of a second attorney certainly has an impact on court decisions beyond (and often in the opposite direction to) those experienced after the addition of full-time patient attorneys. But they also demonstrate that such a system must be designed more carefully than our original efforts and that the precise roles for the attorneys must be spelled out more clearly. If attorneys are allowed to follow their own personal perferences, then their power becomes as arbitrary as that previously attributed to psychiatrists, and far more unpredictable. (Since the study, there have been three more patient attorneys at our hospital, each with markedly differing philosophies—the result has been that the court decisions change each time attorneys change, and neither patients nor their physicians know what to predict; this is hardly a desirable framework in which to treat patients already suffering from inconsistencies and confusion in their internal and external environments).

Since it is clear that some form of adversarial proceedings is here to stay in civil commitment, and that the community pressure as expressed by petitioners and other lay witnesses in our hearings is in the direction of greater use of commitment rather than less,[32,33] systems should be designed that provide clear-cut advocates for both commitment and release positions, so that all participants in the process should have advocates to state their positions forcefully. The role diffusion clearly demonstrated in our present system is frustrating to clinicians and judges and ultimately protects neither patients' civil rights nor their rights to receive effective treatment.

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