Robert D. Miller,[1] *M.D., Ph.D.; Rebecca M. Ionescu-Pioggia,*[2] *B.A.; and Paul B. Fiddleman,*[3] *M.D.*

The Effect of Witnesses, Attorneys, and Judges on Civil Commitment in North Carolina: A Prospective Study

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ABSTRACT: A total of 388 commitment hearings were observed and analyzed for demographic information on patients, name of judge, duration of hearing, identities of those present and those actually testifying, outcome of any procedural challenges, and concurrence of the judges with attorney and physician recommendations. Age, race, and gender of the patient were found to have no significant effect on the outcome of the cases. Disposition of the cases correlated with recommendations by physicians, witnesses, and state attorneys in an overwhelming number of cases. Possible harmful influences of plea-bargaining in commitment hearings are discussed.

KEYWORDS: jurisprudence, psychiatry, mental illness

In a previous study, we investigated the impact of full-time attorneys for both patients and the state on the results of involuntary commitment hearings in North Carolina following statutory changes in 1979. We suggested that a major reason for the observed shift in court decisions from favoring release towards favoring commitment might have been the increased participation in court hearings by lay witnesses from the community (chiefly patients' family members) testifying in favor of continued hospitalization [*1,2*]. As that study was retrospective, and records of court testimony were not available, we undertook the present study to investigate directly the effect of lay witnesses on the results of the hearings, as well as to extend our study on the impact of attorney and physician testimony.

Although involuntary commitment to a number of general and psychiatric hospitals is authorized by North Carolina statutes [*3*], in practice over 80% of all involuntary patients in the state are treated in the four state mental hospitals [*4*]. In contrast to the apparent trend towards decrease in the percentage of involuntary patients [*5-11*], two thirds of patients in North Carolina state hospitals are involuntary [*1,2*]. Involuntary hospitalization can be initiated by any adult petitioner who believes that the criteria for commitment (mental disability plus

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[1]Director of forensic training, Mendota Mental Health Institute, Madison, WI and clinical associate professor of psychiatry and lecturer in law, University of Wisconsin, Madison, WI.

[2]Research consultant, John Umstead Hospital, Butner, NC.

[3]Research psychologist, John Umstead Hospital, Butner, NC and associate professor of psychology, University of North Carolina, Chapel Hill, NC.

dangerousness, as described in NC General Statutes (GS) 122-58.3[a]) are met by a prospective patient. Petitioners can also be physicians (NCGS 122-58.3[d]) or law enforcement officers (NCGS 122-58.18). The statutes require that a hearing be held before a district court judge within ten days of the patient's admission (NCGS 122-58.7). Patients at state hospitals can elect to have their hearings at the hospitals themselves, or in the communities from which they were committed; 90% elect to have their hearings at the hospitals [*1,2*]. As a result of statutory changes in 1977, patients who have their hearings at the state hospitals are represented by full-time attorneys called special counsels (NCGS 122-58.7); further changes in 1979 created four associate attorney general positions at the state hospitals to represent the state's interests (NCGS 122-58.24).

Methods

An observer (Rebecca M. Ionescu-Pioggia) was present in 88% of the weekly district court commitment hearings at John Umstead Hospital, one of North Carolina's four state mental hospitals, from November 1981 through June 1982. Permission for the observer's presence was obtained from each of the four judges and from both attorneys, who were aware of the purposes of the study. In addition, permission was obtained by the special counsel (patient attorney) from each patient whose hearing was observed. It was decided to observe only initial hearings (held within ten days of admission) for adult mental patients as opposed to inebriates. Rehearings (held at 180- or 365-day intervals) are always initiated by hospital physicians, are rarely contested, and seldom feature any testimony, and were therefore not studied. Inebriates are admitted only for detoxification, have brief stays, and had been shown in our previous studies [*1,2*] to be treated by the court significantly differently from mental patients. Hearings for minors were not observed because of logistical difficulties in obtaining consent from parents or guardians; in any event, the majority of minors are admitted by their parents or guardians under provisions for voluntary admission of minors (NCGS 122-56) and are therefore technically not committed.

The observer recorded the following information: (1) demographic patient information; (2) name of sitting judge; (3) duration of hearing; (4) identities of those present and those actually testifying—patients, physicians, law enforcement officers, and lay witnesses; (5) positions taken by each of the actors, including attorneys—for commitment, release, or no position; (6) whether or not there were any procedural or substantive challenges, and if so what the outcome of the challenge was; (7) activity of the judges; and (8) the disposition of the case.

Interviews were held with both attorneys and all four judges to elicit their opinions, attitudes, and observations concerning the commitment process in their court; the interviews were held midway into the study in order to be able to use preliminary findings to guide some of the questions. Information was also sought from the attorneys at the other three state mental hospitals to allow comparisons of patterns of recommendation and physician/court concurrence between John Umstead Hospital and the other hospitals across the state.

Results

There were 388 hearings on 29 court days observed. Patients were present in 325 of these hearings (83.8%). Hearings held in the absence of patients lasted 1 min or less; the average length of all hearings was 7.10 min, and the average length with patients present was 8.13 min.

Demographics

There were no statistically significant differences in age, race, or gender between categories of patients in any of the comparisons to be made below in this study.

Concurrence with Physician Recommendations

Physicians recommended both category of disposition (inpatient commitment [IC], outpatient commitment [OPC], inpatient commitment followed by a period of outpatient commitment [I&O], or release) and proposed a maximum period, up to 90 days, in the case of commitment recommendations. As shown in Table 1, physicians recommended IC for the majority of patients who came to hearing. The judges' concurrence for category of disposition (not taking into account the duration) with physician recommendations is shown in Table 2. The overall concurrence rate was 87.8%. If cases in which the judge ordered commitment for a lesser period of time than recommended by the physician are considered to demonstrate nonconcurrence, then the rate for IC drops to 71.0% and the overall rate drops to 73.1%.

Physicians testified in person in only nine hearings. In the remaining cases, their recommendations were given in notarized affadavits. Judges concurred with oral recommendations in six of the nine cases.

Activity of Attorneys

The special counsel (patient attorney) recommended a disposition to the court in 101 of the 388 cases (26.0%); Table 1 shows those recommendations and Table 2 shows the judges' concurrence.

In the 89 cases in which both the patient and the special counsel (SC) expressed a preference for disposition, the SC represented the patient's wishes in 48 (53.9%). He recommended a more restrictive disposition (IC or OPC instead of release) in 38 cases (42.7%), and a less restrictive disposition in 3 cases (3.4%).

The SC raised legal objections to the evidence in 76 cases (19.6%). Of the eleven challenges to adequacy of evidence for mental illness, five resulted in a decreased duration of IC and six were rejected by the court. There were 42 challenges to evidence of dangerousness: 22 led to reduction of IC, 1 to OPC instead of IC, and 19 had no impact on disposition. Of the 54 procedural challenges (inadequate evidence on the original petition, improper use of emergency

TABLE 1—*Frequency of recommendations.*

Source	IC, %	OPC, %	I&O, %	Release
Physicians[a]	82.1	2.3	2.6	13.0
Witnesses[b]	81.8	5.7	...	12.5
Patients	0	12.7	0	87.3
Special counsel	7.8	44.1	0	48.1
Attorney general[c]	98.0	0	1.0	1.0
Judges	74.9	5.5	4.7	14.9

[a]Correlation with judges: $r^2 = 0.999$, $P < 0.001$.
[b]Correlation with judges: $r^2 = 0.997$, $P < 0.001$.
[c]Correlation with judges: $r^2 = 0.982$, $P = 0.006$.

TABLE 2—*Court concurrence with recommendations.*

Source	IC, %	OPC, %	I&O, %	Release, %
Physicians	89.0	66.7	70.0	88.0
Witnesses	65.8	20.0	...	0.0
Patients	...	13.8	...	8.9
Special counsel	100.0	17.8	...	38.8
Associate attorney general	69.3	...	0.0	...

commitment, missing dates, times, or other information), 6 led to a less restrictive disposition than recommended by the physician, 18 to a reduction of recommended duration of IC, and 30 had no impact on disposition. (There were objections to more than one element in several hearings.) The SC appealed no cases during the study period.

The associate attorney general (AAG) represents the state's interests, which includes representing the positions of both the hospital staff and of the original petitioners. He took a position in 103 of the 388 cases (26.5%). Table 1 shows his recommendations and Table 2 shows the judges' concurrence.

In the 102 cases in which both the AAG and the physician expressed opinions, the AAG represented the physician's opinion in 89 (87.2%). In the 54 cases in which both the AAG and lay witnesses expressed opinions, the AAG represented the witness' opinion in 43 (79.6%). In the 45 cases in which all three expressed opinions, the AAG concurred with both in 28 (62.2%); with neither in 1 (2.2%); with the physician only in 7 (15.6%); and with the witness only in 9 (20.0%). (All of the witnesses other than physicians had been called by the AAG.)

In interviews with the investigators, both attorneys indicated that they felt a "best interests" role (in which the attorney takes into account what *he* feels is best for the patient, as well as considering the patient's expressed wishes) was most appropriate in dealing with patients. The AAG felt that the physician's opinion should have the most weight, while the SC felt that physicians are too interested in looking for illness, and tend to overdiagnose and to overpredict dangerousness; both felt that the physician's opinion should have more weight in cases where he recommends release. Both attorneys agreed that minor procedural irregularities should be ignored, but they disagreed on the use of OPC without physician recommendations—the AAG being opposed (and not recommending it without physician backing in any hearing) and the SC favoring it as a less restrictive alternative to inpatient commitment. The AAG explained calling few witnesses on two grounds—first, it had become obvious that several of the judges preferred to have testimony from as few witnesses as possible; and second, the large number of cases and the unavailability of witnesses (some of whom live some 240 km (150 miles) from the hospital) until the day of court prevented him from preparing them adequately to testify effectively. The SC called no lay witnesses because of his belief that few would be helpful to his clients. He called a few physicians, when he knew that they would testify in favor of release; but he avoided calling physicians as "hostile" witnesses because he said that they would "blow you away in court," while their written affadvaits were more vulnerable to challenge.

Judges

There were significant differences among the four sitting district court judges (Table 3), all of whom had been holding commitment hearings for at least five years at John Umstead Hospital.

Judge A heard more cases than any other judge; his activity (the number of cases in which he

TABLE 3—*Judges' activity.*

Judge	Cases Heard	Hearing Length, min	Percent Active	Agreed with Physician, %	AAG Active, %	SC Active, %	Percent of Cases Challenged	Percent of Challenges Successful
A	138	5.64	7.2	76.1	27.5	25.4	12.3	29.4
B	110	7.63	16.4[a]	74.5	29.1	34.5	28.2	45.2
C	73	6.97	2.7[b]	83.6[c]	17.8	19.2	43.8	59.4
D	67	9.37	3.0[a]	53.7[b]	34.3	32.8	40.3	51.9

[a] $P < 0.025$.
[b] $P < 0.005$.
[c] $P < 0.001$.

cross-examined witnesses or prevented cross-examination or prevented witnesses from testifying) was intermediate compared with the other judges, as was the average activity of the attorneys in his hearings and his concurrence rates with physician recommendations. The SC challenged fewer cases, and received fewer favorable rulings on those which were challenged, than with any of the other judges.

Judge B held court as many days as Judge A, but heard fewer cases on those days. He was significantly the most active of the judges, and both attorneys were the most active in his court; he heard proportionately more legal challenges from the SC than the other judges, and accepted a higher percentage of them.

Judge C was significantly the least active of all the judges personally, and had the highest concurrence rates with physician recommendations. Both attorneys were less active under him than under any other judge, but paradoxically the SC raised more objections, and had a higher percentage sustained, under Judge C than with the other judges.

Judge D was almost as inactive as Judge C, and his hearings averaged longer than the other judges'. He had by far the lowest concurrence rate with physician recommendations; the attorneys were almost as active as under Judge B; and the rate of challenges and successful challenges was almost as great as with Judge C.

The judges indicated in interviews with the investigators that the changes in attorneys, with the changes in style and philosophy that resulted, had had the most significant impact on judges' decision making in court. All judges said that they preferred the SC to adopt a "best interests" role to the extent of raising challenges in a select few cases only; and they also approved of the relative passivity of both attorneys during the study period as compared with the activity of previous attorneys. Three of the four judges clearly felt that physician testimony was much more important than other opinions, and preferred to be able to accept it in most cases without conflicting views and legal technicalities. All judges felt that procedural irregularities should be considered only when they were of major substantive value (such as no evidence at all presented for dangerousness) and felt that the passivity of the present attorneys allowed them to follow their preferences. All judges supported the use of OPC as a compromise disposition between IC and release, even when physicians felt it to be clinically inappropriate. (The 1979 statutory revisions had inserted a requirement that before OPC could be ordered, that the judge must make "findings of fact" that OPC was both appropriate and available [*12*].)

Physicians recommended OPC in only nine cases; the judge concurred in six of those cases, but ordered OPC in an additional fifteen cases where physicians had felt it to be inappropriate. A combination of inpatient commitment followed by OPC was recommended by physicians in ten cases; the judges concurred in seven, but ordered I&O in an additional eleven cases where the physicians had recommended straight IC.

Lay Witnesses

There were 305 potential witnesses in court during the study period hearings; one or more witness were present in 146 hearings, but there was witness testimony in only 83 hearings, from 91 witnesses. The 214 potential witnesses who did not testify were either prevented from doing so by the presiding judge, or were not called by the AAG (who was responsible for all witnesses who attended court during the study, except for a few of the hospital physicians). Of those who did testify, 74 (81.3%) were family members of the patient; 9 (9.9%) were community mental health officials; 5 (5.5%) were law enforcement officers; and 3 (3.3%) were friends of the patient. As shown in Table 1, the great majority of witnesses testified in favor of IC.

Predictors of Court Disposition

As shown in Table 1, there was significant correlation between the recommendation patterns of physicians, witnesses, and the AAG and the court disposition patterns. However,

when the correlation for disposition and recommendation was examined on a case-by-case basis, none of the actors' recommendations was significantly correlated with the judges' decisions by multiple regression analysis. The only such correlation that was significant was that of the witness's recommendation upon the AAG's recommendation (coefficient of determination $r^2 = 0.907$, $P < 0.05$).

The only other significant correlation discovered was the impact of a class of law students on one court session which they observed. The percentage of cases in which the SC raised legal challenges to evidence (50.0% compared to the average of 27.6%) was significantly increased ($P < 0.005$, χ^2) and the percentage of successful challenges (100% compared to 48.6%) was even more significantly increased ($P < 0.001$, χ^2). The increase in hearing length (from 7.10 to 10.3 min) just missed significance ($P = 0.093$, χ^2).

Another significant finding was that the level of concurrence for all categories of physician recommendations dropped consistently during the eight-month study period, from 90 to 85% ($P < 0.001$, χ^2). The length of hearings also decreased over the same period, from 9.4 to 7.1 min; but these changes did not reach statistical significance.

As shown in Table 4, the changes in attorneys and roles during the three study periods at John Umstead have had significant impact on patterns of court concurrence with physician recommendations; the first two periods [*2*] were characterized by one era with an active adversarial patient attorney opposed by a part-time passive attorney for the state who took no time to prepare cases before court, followed immediately by a change in both attorneys to a patient attorney who decided what the patients' best interests were (often disregarding the patient's expressed wishes) opposed by a full-time state's attorney who was vigorous in bringing petitioners and other lay witnesses into court as well as physicians. The third era is that of the present study. Since the only significant changes in actors or conditions of commitment were these changes in attorneys, one may be justified in laying great weight on those changes.

Table 5 demonstrates that although the patterns of court decisions for the three major categories of disposition varied significantly among North Carolina's four state hospitals ($P < 0.001$, χ^2) during the study period, the level of concurrence with physician recommendations is relatively uniform at the three hospitals that kept statistics, reflecting the patterns of physician recommendations more than that of direct court preferences.

Discussion

There has been much discussion in the literature of determinants of commitment hearing outcomes; early papers were generally critical of what was seen as judicial abandonment of decision making to psychiatrists [*6, 7, 12-16*]. This viewpoint was reinforced by responses from clinicians objecting to what they saw as legal intrusions into clinical decisions [*17*]. There have been some reports on the impact of adversarial patient attorneys [*1, 2, 6, 18-21*] and judges [*2, 19, 20*] on commitment hearings, and other reports of the influence of patients' families on the duration and course of psychiatric hospitalization [*22-24*]; but little effort has been made to study each actor's impact on specific hearing outcomes.

From our previous studies [*1, 2*] we had postulated that changes in attorney's philosophies

TABLE 4—*Impact of attorneys on concurrence.*

	Judges' Concurrence, %		
Physician	SC—Advocate, AAG—Passive, %	SC—Best Interests, AAG—Adversarial, %	SC—Passive, AAG—Passive, %
Inpatient commitment	67	89	89
Outpatient commitment	71	54	67
Release	94	70	88

TABLE 5—*Disposition of cases and concurrence with physicians by hospital.*

Hospital	Percent Committed	Percent Outpatient	Percent Released	Concurrence with Physician, %
Broughton	32	9	59	94.3
Cherry	50	4	46	...
Dorothea Dix	70	2	28	94.1
John Umstead	80	5	15	87.8

would have a major impact on the outcomes of commitment hearings, as the patient population, judges, and hospital staff had not changed appreciably. We had also postulated that lay witnesses played a major part in court decisions because of the significant incidence of commitments when physicians recommended release (Table 4, second column). In such cases, evidence leading to commitment could have come only from lay witnesses, called by the AAG.

This prospective study allowed us to examine these hypotheses more directly. The data support the proposed impact of attorney activity as a modifier of court concurrence with physician recommendations. The increase in concurrence for IC seen over previous studies (Table 4, Column 1) can be explained by the relative passivity of the SC as compared with his adversarial predecessor; and the increase in concurrence for release (Table 4, Column 2) can similarly be explained by the relative passivity of the present AAG as compared with the more active original AAG. This interpretation is confirmed by the statements made by the judges and both attorneys in their interviews with the investigators.

We were not able to confirm our hypothesis that lay witness testimony had significant impact on court disposition; although judges' patterns of disposition closely paralleled witnesses wishes when taken overall, case-by-case examination did not reveal significant correlation. There are several possible explanations for this finding. The previous AAG had emphasized witness testimony more than the present AAG, and had insisted on witnesses being allowed to testify, particularly when they recommended IC and their physician recommended release [*1,2*].

During this study period, the judges frequently indicated directly that they did not want lay testimony. Potential witnesses often lived long distances from the hospital; many did not have telephones and could be contacted only by letter before the hearings. Most had never been in a court before, and many were reluctant to testify against a family member, even if they had initiated the commitment proceedings. There was no time during court days to prepare witnesses for testifying, or even to determine what they would say on the stand. Witness testimony therefore tended to be hesitant, and often not directly relevant to the legal issue, thus decreasing its potential weight and reinforcing the judges' disinclination to hear it.

While the majority of witness testimony favored IC, most of the lay witnesses made it clear that they wanted the patient to remain hospitalized only as long as necessary for him or her to be cured of the condition which had required hospitalization. Most indicated they wanted the patient back again, but only after the behavior had been changed so that it would not recur. They did not display much understanding of the legal issues upon which the decision was made, and were often confused or upset if the court came to a determination different from their recommendations.

In much of the literature concerning civil commitment, there seems to be an implicit assumption by legal scholars that a high concurrence rate between physician recommendations and court decisions is inherently bad, despite the viewpoint that if court hearings provide sufficient time for both sides of the issue to be presented, high concurrence rates do not necessarily reflect undue judicial deference to psychiatrists [*1,2,4*]. This study has demonstrated another factor—that physicians' behavior can be modified significantly by court expectations of them. Psychiatrists, like other physicians, have been trained to provide treatment under whatever conditions are necessary to assure maximum effectiveness of that treatment, including involuntary hospitalization if necessasry. If those necessary conditions include learning

how to present legally relevant testimony to the court, they will learn to do so; if it means modifying recommendations because of expected court response, they will do that as well, as demonstrated by the significant differences in patterns of recommendations at North Carolina's four state hospitals, which serve quite similar patient populations.

Less mention has been made of attempts to modify the actions of judges. The number of criticisms of judicial deference to psychiatrists, backed up by specific interviews with judges in our study and in that of Zander [*19*], indicates that many, if not most, judges continue to see commitment as basically a clinical decision, and prefer to give great weight to psychiatrists, if they are not coerced to do otherwise. The chief effective method of such coercion is appeal to a higher court. It is significant that under the initial period of our previous study, [*1,2*] the SC instituted a number of such appeals, many of which were sustained; during that period, the judges accepted a number of procedural challenges because of the fear of appeal. Special counsels at the other three state hospitals in North Carolina have continued to raise at least some appeals, while none have come from John Umstead; therefore the judges feel freer to follow their basic preferences to give greatest weight to psychiatric testimony wherever possible. Even given these preferences, however, the lack of significant correlations between physician recommendations and court dispositions on a case-by-case basis demonstrates the effective independence of the judges in our court from undue physician influence.

Plea Bargaining

Much has been made of the "criminalization" of the civil commitment process in the literature [*17,25*]; most of the emphasis has been on the adversarial system for patient representation or on the criteria and standards for burden of proof. Our study reveals another criminal justice procedure that has become grafted on civil commitment—plea bargaining. Gupta, in his review of New York's Mental Health Information Service [*6*], comments favorably on the fact that the number of patients who actually come to court hearings has been drastically reduced by prehearing negotiations between patient attorneys and hospital physicians. In North Carolina, this process is indirect—SCs rarely spend time talking to physicians at John Umstead Hospital—but nevertheless effective. Physicians learn quickly what the criteria are at a given time for commitment, and tailor their recommendations to those standards. This is one explanation for the high concurrence rate observed at all four state hospitals in North Carolina (Table 5), despite greatly different proportions of recommendations for IC.

But plea bargaining is also quite explicit in the hearings. The SC recommended a more restrictive disposition than that desired by his client in 43% of cases in which he expressed an opinion. In interview, he stated that this was clearly an attempt on his part to plea bargain, based on his impression that the patient's wishes were unlikely to be heeded, but that the court might agree to a compromise. The judges also felt that their decisions to order OPC despite physician recommendations to the contrary were justified on the same principle of plea bargaining, as a compromise between what the patient wanted and what the physician recommended in cases in which the evidence did not, in the judges' opinion, justify the physician's recommendation. The reduction in duration of IC as compared to the time period recommended by the physician, which occurred in 18% of cases in which physicians recommended IC, is another example of judges' compromising between physician recommendations for a length of time they feel necessary to provide effective treatment, and legal inadequacies in the physician's evidence for the recommendation.

As with other elements of the criminal justice system that have been added to the civil commitment process (and have received much more attention), there are significant problems with plea bargaining as used in commitment proceedings. Unlike the situation in criminal court, in which the decisions are often simply a matter of duration of sentence, the results of plea bargaining in civil commitment involve major alterations in therapeutic options. While duration of criminal sentences is an arbitrary determination, based on society's perception of the seri-

ousness of the offense and its need for protection for the offender, commitment recommendations are based upon clinical estimates of how long treatment will take, and of what clinical setting is necessary for that treatment to be effective. If effective treatment is to be a major goal of civl commitment (as is explicitly stated in the statutes of a number of states), then a judicial determination of treatment setting or duration is inappropriate.

Judges and attorneys often counter such arguments by raising the "least restrictive environment" provisions of the statutes; but those statutes indicate that the concept means the least restrictive environment in which the patient can be *appropriately* treated (NCGS 122-58.1), which is (or should be) a clinical, not a legal, judgment.

The judges in our interviews, and other judges quoted elsewhere, claim strongly that they are not clinicians and do not want to make clinical decisions; but when they choose a treatment setting or duration against the explicit advice of clinicians, they are doing just that. The law does require judges to determine whether or not a patient meets the state's criteria for involuntary treatment; that *is* a legal and not a clinical determination. But the duration and location of treatment is not (or should not be) a legal decision, which a number states have recognized statutorily by delegating to the department of mental health the determination of the site of treatment. The kinds of plea bargaining compromises we have seen satisfy no one if enforced (and outpatient commitments made against the advice of clinicians both at the hospitals and the outpatient facilities are seldom enforced [*26*]) and typically result in "revolving door" rehospitalizations.

Conclusions

One of the major benefits from psychiatric hospitalization from a clinical viewpoint is the creation of a consistent psychological environment within which severely disturbed patients can recover. Predictability and continuity of care are essential for reintegration of severely ill patients. The current operation of the legal system is making the maintenance of such environments extremely difficult. Patients are presented with mixed messages from their physicians and from the court. When they are released because of a legal interpretation of evidence, they frequently take it as disagreement with the psychiatrists that the patient in fact has a mental disorder and needs treatment. (In fact, this did not occur once—the successful objections to evidence for mental illness were to statements made by physicians outside the hospital, and indicated that what was written down did not satisfy the legal requirements, not that no mental illness was present.) Such perceived statements makes it even more difficult for family members and for clinicians both inside the hospital and in the community to convince the patient to accept needed help. And when the pattern of court decisions changes every time new attorneys arrive, it becomes even more disorganized, to the point that clinicians as well as patients begin to lose faith in the system.

If we are to balance the legitimate freedom interests of the legal community with the equally legitimate treatment interests of clinicians, we must create a system with more legal stability, and one in which judges are not forced into making treatment decisions. And it must be made more clear to patients, by the *legal* personnel who have assumed the power, that court decisions speak only to legal criteria, not to illness or need for treatment. Finally, the practice of judicial determinations of clearly inappropriate treatment settings must be abandoned.

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Address requests for reprints or additional information to
Robert D. Miller
Director of Forensic Training
Mendota Mental Health Institute
301 Troy Dr.
Madison, WI 53704