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Virginia Aldige Hiday

THE ATTORNEY'S ROLE IN INVOLUNTARY CIVIL COMMITMENT

VIRGINIA ALDIGÉ HIDAY†

Involuntary commitment respondents in North Carolina are guaranteed the right to be represented by counsel. The role of counsel in commitment proceedings is not enunciated clearly in statutes, case law or the code of ethics. There are several models of counsel participation in the commitment process, ranging from a strict adversarial stance to a paternalistic assessment of the client's best interests. Professor Hiday has conducted a large-scale study of involuntary commitment in North Carolina, and part of this study focused on the performance of attorneys in the commitment process. Professor Hiday questioned attorneys about what they felt their roles should be, how they viewed their clients, what preparation was done, and the effects of these factors on the commitment proceedings. In this Article Professor Hiday shares her observations on these aspects of civil commitment. She concludes by suggesting some guidelines for improving the performance of attorneys in the civil commitment process.

The North Carolina General Statutes grant the right to be represented by counsel to respondents against whom petitions have been brought for involuntary hospitalization.[1] At each of the four state mental hospitals,[2] the State employs an attorney (Special Counsel) to work full-time representing all persons against whom a petition for involuntary commitment has been brought.[3] In judicial districts without state mental hospitals, the State pays appointed counsel or public defenders to represent respondents unless a respondent retains private counsel.[4]

But what does having counsel in civil commitment mean? What functions does an attorney perform in representing persons alleged to be dangerously mentally ill?[5] Presumably, legal representation is the key to assuring

† Associate Professor of Sociology, North Carolina State University and Visiting Associate Professor of Psychiatry, University of North Carolina School of Medicine. A.B. 1960, Ph.D. 1973, University of North Carolina at Chapel Hill. This research was supported by Grant Number 5 RO1 MH 30548 from the Center for Crime and Delinquency Studies of the Alcohol, Drug Abuse and Mental Health Administration of the National Institute of Mental Health. The author wishes to thank the judges, counsel and clerks without whose cooperation this study would not have been possible.

1. N.C. Gen. Stat. § 122-58.7(c)(1981).

2. The four State mental hospitals are Broughton in Morganton, Umstead in Butner, Dix in Raleigh, and Cherry near Goldsboro.

3. N.C. Gen. Stat. § 122-58.12 (1981).

4. Id. § 122-58.7(e).

5. This Article deals with representing only the allegedly dangerous mentally ill in civil commitment. Allegedly dangerous inebriates and the mentally retarded who are allegedly dangerous because of an accompanying behavior disorder may be committed as well, and thus they also are provided counsel. Id. §§ 122-58.1 to -.7(e).

that due process rights are protected;[6] but beyond insisting on the regularity of proceedings, counsel's role in civil commitment is not clearly specified in legal tradition, statutes, case law or the *Model Code of Professional Responsibility*.[7] As in any other type of case, an attorney should act to further his client's best interests; but in the area of civil commitment, there is little agreement on what constitutes the client's best interests or on who should decide what his or her best interests are.

This lack of agreement stems from an inherent tension between the intended beneficence of the law and the perceived harshness of the incarceration and the loss of liberty that are required to give medical help. The state in its *parens patriae* role seeks to secure psychiatric treatment and eventual mental health for those who are unable to secure this help on their own. Yet, in the process of securing help, civil commitment acts to take away the personal freedom of individuals. This aspect of civil commitment is especially noticeable when the state acts on authority derived from its police power to hospitalize persons who are allegedly dangerous to others.

If an attorney focuses on the loss of liberty resulting from involuntary hospitalization, he would take the position that his client's best interests lie in preventing such loss. Accordingly, his role would be to assume an adversarial stance towards the commitment petition and to argue against commitment. On the other hand, if an attorney focuses on the pain and suffering accompanying mental illness and the possibility of alleviating that pain through treatment in a mental hospital, he would argue that a client's best interests lie in obtaining treatment even if this requires his client to be hospitalized involuntarily. His role in this instance would be to facilitate hospitalization by not assuming a traditional adversarial position.

Who then is to decide a client's interests—the attorney or the client? If the client is mentally ill, he may be unable to recognize his own best interests. Should the lawyer then make the decision? But how can the lawyer determine that the client is mentally ill and needs hospitalization when the question of the client's mental illness is before the court? Even if the client is mentally ill, there is no reason to assume that he is necessarily incapable of rational decisions.[8] Additionally, because lawyers are not trained to recognize mental ill-

6. Anders v. California, 385 U.S. 738, 744 (1967); Powell v. Alabama, 287 U.S. 45, 68-69 (1932).

7. Model Code of Professional Responsibility (ABA) (1971). For a full discussion of how little guidance attorneys are given on their role in civil commitment, see Goode, The Role of Counsel in the Civil Commitment Process: A Theoretical Framework, 84 Yale L.J. 1540 (1975).

8. Only some mental disorders prevent persons from rational thinking; even then, the person may be capable of rational thinking in some areas and in some periods. See generally Task Force on Nomenclature and Statistics, American Psychiatric Association, Diagnostic & Statistical Manual of Mental Disorders (3d ed. 1980).

In North Carolina, mental illness is clearly separated from incompetency in that adjudication of legal incompetency has no effect on mental hospitalization and vice versa. See N.C. Gen. Stat. § 122-55 (1981). The distinction between incompetency and mental illness has also been drawn by federal courts in cases involving the right to refuse treatment. In Winters v. Miller, 446 F.2d 65 (2d Cir. 1971), and in Rogers v. Okin, 634 F.2d 650 (1st Cir. 1980), cert. granted, 451 U.S. 906 (1981), the courts ruled that an involuntary mental patient is capable of deciding against psychiat-

ness, they may be unqualified to make the initial determination that a person is mentally ill and unable to recognize his own best interests. Often they rely totally on psychiatric opinion. This deference forces the psychiatrist to assume the position of determining a client's best interests and thus to determine commitment itself if the psychiatrist decides that it is in the best interest; commitment rates are extremely high (up to one-hundred percent) in the absence of an adversarial stance by counsel towards commitment.[9]

When lawyers allow the client to determine his own best interests and advocate against commitment, the assumption of an adversary role is still difficult because civil commitment courts tend to be unbalanced in the representation provided each party. In most civil commitment courts throughout North Carolina and the United States, the state—as petitioner—is not represented by legal counsel.[10] This imbalance upsets the logic of the adversarial system, which assumes that the best way to achieve justice is for counsel on each side to present the case most favorable to his client. From conflicting testimony and argument, the judge will be able to synthesize the fairest and most humane decision.[11] In the absence of an adversarial proceeding, facts to substantiate a finding of mental illness and dangerousness may not be brought to light in court unless a judge assumes the awkward role of examiner as well as judge. Even when the judge assumes this dual role, the imbalance is not fully rectified because no prehearing investigation informs the judge of appropriate areas for questions. Furthermore, the judge can question only those witnesses who are present, which in many cases may be only witnesses who are favorable to the respondent. This lack of balance combined with the tension between beneficence and incarceration creates ambiguity in the roles of counsel and the court.

Prior to the spread of the civil rights movement into the area of mental health, the ambiguity was resolved in favor of the *parens patriae* foundation of civil commitment that dominated the thinking of legislatures, courts and counsel.[12] Focus on the beneficent aspects of commitment led courts to defer to the opinions of psychiatrists in determining the best interests of the allegedly men-

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ric treatment unless there is a separate finding of incompetency. See D. Wexler, Mental Health Law: Major Issues 39-51 (1981).

9. For empirical research reports of these findings, see Andalman & Chambers, Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic and a Proposal, 45 Miss. L.J. 43 (1974); Cohen, The Function of the Attorney in the Commitment of the Mentally Ill, 44 Tex. L. Rev. 424 (1966); Hiday, The Role of Counsel in Civil Commitment: Changes, Effects, Determinants, 5 J. Psychiatry & L. 551 (1977); Litwack, The Role of Counsel in Civil Commitment Proceedings: Emerging Problems, 62 Calif. L. Rev. 816 (1974); Zander, Civil Commitment in Wisconsin: The Impact of *Lessard v. Schmidt*, 1976 Wis. L. Rev. 503; Special Project, The Administration of Psychiatric Justice: Theory and Practice in Arizona, 13 Ariz. L. Rev. 1 (1971); Project, Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation, 64 Iowa L. Rev. 1284 (1979) [hereinafter cited as Iowa Project].

10. N.C. Gen. Stat. § 122-58.24 (1981) provides for the representation of the State in commitment hearings only at the four regional mental hospitals. There is no provision for the representation of the State in commitment proceedings at other locations.

11. J. Frank, Courts on Trial: Myth and Reality in American Justice (1949); Barrett, The Adversary System and the Ethics of Advocacy, 37 Notre Dame Law. 479 (1962); Goode, supra note 7; Zander, supra note 9.

12. N. Kittrie, The Right to Be Different (1971); D. Wexler, supra note 8, at 39-51.

tally ill. Indeed, the deference was so great that courts essentially defaulted in their responsibility to make judicial determinations for commitment.[13] Abuses were plentiful, and many persons who were neither mentally ill nor dangerous found themselves involuntarily hospitalized for indefinite periods. In most cases, attorneys did essentially nothing to assure their clients of procedural or substantive protection.[14]

In various studies in six states, respondents' lawyers were described in terms such as reticent,[15] ineffective,[16] ill-prepared,[17] mostly silent,[18] lacking interest,[19] rarely extending any effort,[20] giving only perfunctory representation,[21] doing little or nothing to obtain a client's release[22] and seldom challenging adverse statements by witnesses or adverse psychiatric testimony.[23] Lawyers did not explore in court such elemental legal questions as whether there was any factual basis for a conclusion of dangerousness, whether medical examinations were thorough, whether a physician's recommendation was based on conclusory data and whether alternatives to involuntary hospitalization existed.[24] Furthermore, in the typical case, counsel hardly could have known the answers to these questions or been familiar with the facts of a case since most interviews with clients occurred only a few minutes before hearings and were quite brief.[25] Attorneys in these studies expressed a lack of medical expertise and a need to rely on psychiatric reports that recommended involuntary hospitalization.[26] Legal scholars have argued that with such deference to psychiatry, commitment hearings become "an empty ritual"[27] and "add a falsely reassuring patina of respectability to the proceedings."[28]

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13. Not all states provided court hearings for civil commitment. Many states allowed commitment, even in nonemergencies, based on medical certification; and a number of states placed the commitment decision in the hands of an administrative board that generally had physician representation. Counsel was not always provided even in those states with court hearings. American Bar Foundation, The Mentally Disabled and the Law (S. Brakel & R. Rock rev. ed. 1971); Developments in the Law, Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190 (1974).

14. Cohen, supra note 9; A. Dershowitz, Psychiatry in the Legal Process: A Knife That Cuts Both Ways, 51 Judicature 370 (1968); Ennis & Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 Calif. L. Rev. 693 (1974); Special Project, supra note 9; Developments in the Law, supra note 13.

15. Contemporary Studies Project, Facts and Fallacies About Iowa Civil Commitment, 55 Iowa L. Rev. 895, 918 (1970).

16. Cohen, supra note 9, at 425; Special Project, supra note 9, at 54.

17. Cohen, supra note 9, at 424; Contemporary Studies Project, supra note 15, at 913-14.

18. See Cohen, supra note 9, at 429.

19. Id. at 424.

20. Andalman & Chambers, supra note 9, at 43-44, 72; Cohen, supra note 9, at 424.

21. Special Project, supra note 9, at 52.

22. See Cohen, supra note 9, at 429.

23. Dix, Hospitalization of the Mentally Ill in Wisconsin: A Need for Reexamination, 51 Marq. L. Rev. 1, 9-10 (1967); Special Project, supra note 9, at 52.

24. Cohen, supra note 9, at 429; Dix, supra note 24, at 9-10. See Andalman & Chambers, supra note 9, at 59-60; Special Project, supra note 9, at 51-52.

25. Andalman & Chambers, supra note 9, at 43; Special Project, supra note 9, at 54; Contemporary Studies Project, supra note 15, at 914.

26. Special Project, supra note 9, at 53.

27. Cohen, supra note 9, at 448.

28. Andalman & Chambers, supra note 9, at 72.

Not all early studies found attorneys to be passive in civil commitment hearings. One study[29] reported that respondents represented by counsel, as opposed to those without legal representation, had significantly fewer commitments and had significantly longer hearings notwithstanding the actual mental condition of the respondent involved in the hearing. Since attorneys in that study were not provided by the State,[30] it is likely that the lawyers were privately retained for the sole purpose of fighting commitment. In the case of state-appointed representatives or public defenders, adversarial roles may not be so frequently performed.[31] A more recent study[32] in Nebraska reported that there were proportionately fewer commitments among respondents represented by private counsel than among those represented by appointed counsel or public defenders. In fact, the latter group had no fewer commitments than the group of respondents without any legal representation.[33]

The spread of the civil rights movement into the area of civil commitment directed attention to the punitive nature of involuntary hospitalization and to the abuses[34] that commonly occurred when the state paternalistically assumed the care and custody of allegedly mentally ill persons.[35] By emphasizing the essential police function of mental commitment, civil rights advocates fought for and obtained, from both federal courts and state legislatures, two major limitations on state commitment power: (1) application to the commitment procedures of the principles of due process, including notice, hearing, confrontation of witnesses, counsel and judicial review;[36] and (2) establishment of a requirement of dangerousness coupled with mental illness for involuntary hos-

29. Wenger & Fletcher, The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions, 10 J. Health & Soc. Behav. 66 (1969).

30. Id.

31. For a full discussion of this point, see Goode, supra note 7; Litwack, supra note 9. In our study, we observed one case to which an attorney was court-appointed but later removed when the respondent retained private counsel. Both the respondent and his family wanted release. Private counsel harbored no doubt about his role; hence, he assumed an adversary role to fight commitment on both procedural and substantive grounds. His client's release was obtained; however, if appointed counsel had represented this respondent he would not have assumed an adversary role and the respondent would not have been as likely to obtain release. The attorney appointed by the court told the privately retained counsel that he had read the legal record (consisting of the petition by a physician and the psychiatrist's affidavit) and on that basis knew the respondent needed to be committed as dangerous.

32. Peters, Teply, Wunsch, & Zimmerman, Administrative Civil Commitment: The Ins and Outs of the Nebraska System, 9 Creighton L. Rev. 266 (1976).

33. Id. at 279-80.

34. For instance, one man was confined in a state mental hospital on the basis of an initial petition alleging delusions and on the basis of a brief psychiatric exam finding paranoid schizophrenia. He was never thought to be dangerous, and several people in the community were willing to assume responsibility for him. See K. Miller, Managing Madness: The Case Against Civil Commitment 20-26 (1976). See also O'Connor v. Donaldson, 422 U.S. 563 (1975).

35. Dershowitz, supra note 14, at 373-77; Hiday, Reformed Commitment Procedures: An Empirical Study in the Courtroom, 11 Law & Soc'y Rev. 651 (1977); Zander, supra note 9, at 504; Special Project, supra note 9, at 5-8.

36. E.g., O'Connor v. Donaldson, 422 U.S. 563 (1975); In re Bailey, 482 F.2d 648 (D.C. Cir. 1973); Heryford v. Parker, 396 F.2d 393 (10th Cir. 1968); Bell v. Wayne County Gen. Hosp., 384 F. Supp. 1085 (E.D. Mich. 1974); Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972), vacated and remanded for a more specific order, 414 U.S. 473, order on remand, 379 F. Supp. 1376 (1974), vacated and remanded on other grounds, 421 U.S. 957 (1975), order reinstated on remand, 413 F. Supp. 1318 (1976); Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972), aff'd in part sub. nom.

pitalization.[37] Implied in these procedural and substantive changes is the expectation that the court will reach its result on legal grounds rather than depend upon purely psychiatric information.[38] The court may accept medical opinion; but to achieve the intended independence from psychiatric expertise, it must refuse to accept psychiatric conclusions without supporting facts. What are the implications for the role of counsel under these new directions in civil commitment law?

Most reform statutes have not defined the role of counsel, and only a few courts have spoken directly to the issue. The three-judge federal district court that decided *Lessard v. Schmidt*,[39] the most extensive explication of civil commitment law based on the state's police power, held that counsel should assume an adversarial role, acting as an advocate for his clients' expressed wishes.[40] The court found that appointment of a guardian ad litem who would work within a paternalistic model "cannot satisfy the constitutional requirement of representative counsel."[41] In another case, the Washington Supreme Court held that even if a statute required appointment of a guardian ad litem, counsel was to act as an advocate for his client and could not waive any fundamental rights without the client's consent.[42] Similar conclusions have been reached by a federal district court in Alabama[43] and by the Supreme Court of West Virginia.[44]

The ABA Commission on the Mentally Disabled also recommended an adversarial role for counsel in civil commitment proceedings. The Commission's proposed statute states that an attorney shall "serve as advocate for the client's liberty, release or such alternative placement as the client desires."[45] At the level of the practicing attorney in the civil commitment court, however, there has been no general acceptance of an adversarial role.

After *Lessard*, Wisconsin's attorneys assumed either an adversarial or a paternalistic role according to the judge's view of the foundation for civil commitment. In courts in which the foundation was *parens patriae*, appointed attorneys assumed a passive role, and there was a higher commitment rate than in courts in which the foundation was police power and appointed counsel

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Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). See generally D. Wexler, supra note 8, at 209 n.44; Developments in the Law, supra note 13.

37. By 1978, 48 states had adopted commitment codes that incorporated dangerousness into their criteria for involuntary commitment to a mental facility. Schwitzgebel, Survey of State Civil Commitment Statutes, in Civil Commitment and Social Policy 47-83 (A. McGarry, R. Schwitzgebel, P. Lipsitt & D. Lelos eds. 1981).

38. See also Humphrey v. Cady, 405 U.S. 504, 509 (1972) (dictum). See generally Special Project, supra note 9.

39. 349 F. Supp. 1078 (E.D. Wis. 1972), vacated and remanded for a more specific order, 414 U.S. 473 (1974).

40. Id. at 1097-99.

41. Id. at 1099.

42. In re Quesnell, 83 Wash. 2d 224, 234-40, 517 P.2d 568, 575-78 (1974).

43. Lynch v. Baxley, 386 F. Supp. 378 (M.D. Ala. 1974), rev'd on other grounds, 651 F.2d 389 (5th Cir. 1981).

44. State ex rel. Hawks v. Lazaro, 202 S.E.2d 109 (W. Va. 1974).

45. ABA Comm. on the Mentally Disabled, Legal Issues in State Mental Health Care: Proposals for Change 286 (1981).

assumed an active adversary role.[46]

Following reform in New York, attorneys[47] representing respondents in civil commitment hearings varied in the role they assumed depending upon their evaluation of each case.[48] When they assumed an adversary role seeking their client's release both before and during hearings, the commitment rate was significantly lower because psychiatrists discharged respondents outside of court or because the court ordered release.[49]

The reform statute in Iowa required that civil commitment hearings be conducted in an adversarial manner;[50] however, attorneys continued to defer to medical expertise. Accordingly, they rarely employed adversarial techniques such as vigorous cross examination of witnesses and second psychiatric examinations,[51] available at state expense.[52] Most referees in Iowa favor a paternalistic model and nonadversarial hearings.[53] Under these conditions it is not surprising that attorneys do not assume an adversarial stance. Several attorneys stated that, given the referees' predilections, an adversarial stance would hurt their clients' chances of release.[54]

Despite heavy publicity surrounding California's passage of the Lanterman-Petris-Short Act[55] and its emphasis on protection of individual rights, many lawyers assumed a paternalistic role in the commitment process and ritualistically moved through the motions of legal form.[56] One public defender who vigorously advocated his client's release was dismissed from his job for failing to share the paternalistic viewpoint of the judge and other public defenders.[57]

In one Virginia county, court-appointed attorneys in civil commitment regularly waived all of their clients' rights, failed to assure that commitment criteria were addressed in court and assisted the court in rushing through perfunctory hearings.[58] Every one of their clients was involuntary hospitalized.[59]

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46. See generally Zander, supra note 9.

47. These attorneys worked full-time for the Mental Health Information Service, a state agency designed to help both respondents and the court in legal and social problems that might arise as a result of civil commitment. Kumasaka & Gupta, Lawyers and Psychiatrists in Court: Issues on Civil Commitment, 32 Md. L. Rev. 6, 6 (1972).

48. Kumasaka & Stokes, Involuntary Hospitalization: Opinions and Attitudes of Psychiatrists and Lawyers, 13 Comprehensive Psychiatry 201 (1972).

49. Id. See also Kumasaka, Stokes & Gupta, Criteria for Involuntary Hospitalization, 26 Archives Gen. Psychiatry 399 (1972).

50. Iowa Code § 229 (Supp. 1981). See Bezanson, Involuntary Treatment of the Mentally Ill in Iowa: The 1975 Legislation, 61 Iowa L. Rev. 261 (1975).

51. Iowa Project, supra note 9, at 1405-06, 1411.

52. Iowa Code §§ 229.10(1), .12(1) (Supp. 1981).

53. Iowa Project, supra note 9, at 1396-97, 1411.

54. Id. at 1396-97.

55. Law of Sept. 2, 1967, ch. 1667, § 36, 1967 Cal. Stat. 4053, 4074 (codified as amended at Cal. Welf. & Inst. Code §§ 5000-5466 (West 1972 & West Supp. 1981)).

56. C. Warren, Court of Last Resort: Judicial Review of Involuntary Civil Commitment in California __ (in press 1982). In the Los Angeles court under study, lawyers from the public defender's office provided legal representation in civil commitment. Id. at __.

57. Id. at __.

58. Complaint and Motion to Proceed Anonymously, Woe v. Arlington County Gen. Dist. Court, Civ. No. 79-79-A (E.D. Va. complaint dismissed Mar. 23, 1979).

Following litigation and consequent press attention, legal representation reportedly is more active.[60]

A study conducted one year after the 1973 reform in North Carolina[61] showed that appointed counsel varied widely in the roles they performed.[62] Most did not argue in any way for their clients' release.[63] In a substantial minority of cases, however, attorneys did assume an adversarial role by challenging adverse testimony, presenting evidence favorable to their clients, and making direct arguments to the court in favor of release or alternative treatment.[64] In these cases the commitment rate was significantly lower than in those cases in which the attorney assumed a nonadversarial stance.[65]

One might infer that respondents whose attorneys did not advocate release and who were subsequently committed were more mentally ill and more dangerous than respondents whose lawyers argued for release; however, this has not been the case. Many respondents in these studies were committed without the statutorily required evidence of dangerousness.[66] In Iowa, respondents were committed on the basis of little evidence beyond unchallenged medical testimony;[67] those committed in Wisconsin courts under a *parens patriae* foundation rarely had evidence of acts of substantial harm to self or others presented against them.[68] In the North Carolina study, forty-two percent of contested cases resulted in commitments without clear, cogent and con-

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59. Id. The Mental Health Law Project brought suit in federal court to assure that civil commitment respondents in this count would receive effective representation. The case was dismissed without opinion. Woe v. Arlington County Gen. Dist. Court, 620 F.2d 296 (4th Cir. 1980) (mem.).

60. Mental Health Law Project, A Summary of Activities, July 1979-June 1981 (1981).

61. In 1973 the General Assembly repealed Law of June 25, 1963, ch. 1184, § 2, 1963 N.C. Sess. Laws 1640, 1647-48, which had provided for admission to mental health facilities by medical certification, and enacted a new law providing for commitment proceedings. Law of May 23, 1973, ch. 726, §§ 1, 2, 1973 N.C. Sess. Laws, 1st Sess. 1074 (codified as amended at N.C. Gen. Stat. § 122-58.1 to .23 (1981)).

62. Hiday, supra note 9.

63. Id. at 558-60.

64. Id. at 559.

65. Id. at 560.

66. Based on criteria developed for the Hiday study. Id. at 561. Questions about mental illness, also required for commitment, rarely were raised because attorneys and judges saw mental illness as being clearly in the realm of medical expertise. If a psychiatrist diagnosed mental illness, it was generally accepted as fact. Id.

67. Iowa Project, supra note 9.

68. Zander, supra note 9. Following this study, commitments in the *parens patriae* court were appealed to a higher court. Citing counsel's failure to cross examine two of every three witnesses and their asking an average of only two questions per witness, the Wisconsin circuit court indicted the shoddy legal representation of respondents committed by this court. Wisconsin ex rel. Memmel v. Mundy, No. 441-417, slip op. (Wis. Cir. Ct. Aug. 18, 1976), appeal dismissed and rights declared, 75 Wis. 2d 276, 249 N.W.2d 573 (1977). It went on to say:

> The record presented by this case is as bleak a picture as has probably ever been presented of justice in Milwaukee County. A massive and systematic deprivation of the constitutional rights of people who are unable to voice their own protests has been accomplished by the cooperation of the bench and bar of Milwaukee County. . . . [T]he onus of the debacle lies squarely with the lawyers and judges who operated this "greased runway" to the county mental health center . . . .

Id., slip op. at 15.

vincing evidence of imminent danger.[69] Researchers in these studies concluded that an adversarial stance by counsel would have prevented commitments in those cases that did not meet the criteria of dangerousness and in those cases in which the state was not prepared to put forth evidence to make its case.[70]

To summarize, despite recent judicial and statutory emphasis on the deprivation of liberty in civil commitment and the accompanying substantive and procedural reforms, lawyers throughout the United States have not consistently changed their approach to an adversarial role in representing respondents.[71] Many still cling to a paternalistic model. Furthermore, many lawyers still defer to psychiatric opinion without employing careful fact-finding techniques to assure that only those who meet the statutory criteria are committed. Some attorneys refrain from assuming an adversarial role because the presiding officer of the court views commitment paternalistically; others refrain because they themselves view commitment paternalistically and defer to medical opinion. Some dispense with an adversarial role because there is no legal representation for the State/petitioner and the court would not be able to weigh all evidence. Still others fail to advocate their respondents' interests only when they make up their own minds that their clients meet the commitment criteria.

In an effort to determine how lawyers and judges in North Carolina view their role in the civil commitment process, the author conducted a study seeking the answers to such questions as: How do counsel in this state view their role after the basic procedural and substantive reforms have been in operation for a substantial period of time?[72] Are attorneys in North Carolina different from attorneys in other states? Are there systematic differences between those attorneys working full-time representing civil commitment respondents in state mental hospitals and those appointed counsel and public defenders in judicial districts without a state mental hospital? We sought answers to these questions directly, by asking counsel and judges who participate in civil commitment hearings how they view counsel's role; and indirectly, by recording attorney behavior in civil commitment hearings and in preparation for these hearings.

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69. Based on criteria developed for the study. Hiday, supra note 35, at 663. At the time of the North Carolina study, the statute required that the danger to self or others be imminent. "Imminently" was removed as a qualifier of "dangerous" in G.S. 122-58.1 by Law of June 8, 1979, ch. 915, § 2, 1979 N.C. Sess. Laws, 1st Sess. 1260 (codified at N.C. Gen. Stat. § 122-58.1 (1981)).

70. See Hiday, supra note 9. See also Developments in the Law, supra note 13, at 1283-90, 1394-98.

71. See text accompanying and articles cited in notes 46-59 supra.

72. The basic reform of civil commitment procedures and criteria occurred in 1973. See note 61 supra. Since that time the statutes have been revised to clarify some areas of confusion, to rectify technical problems in the proceedings, and to improve the general functioning of the commitment process. See, e.g., Law of Apr. 13, 1973, ch. 1408, 1973 N.C. Sess. Laws, 2d Sess. 783; Law of May 17, 1977, ch. 400, 1977 N.C. Sess. Laws, 1st Sess. 402; Law of June 22, 1977, ch. 679, 1977 N.C. Sess. Laws, 1st Sess. 805; Law of June 24, 1977, chs. 738-39, 1977 N.C. Sess. Laws, 1st Sess. 962; Law of June 8, 1979, ch. 915, 1979 N.C. Sess. Laws, 1st Sess. 1260 (these modifications have been codified at N.C. Gen. Stat. §§ 122-58.1 to .26 (1981)).

THE NORTH CAROLINA STUDY

As part of a larger study of 1135 civil cases throughout North Carolina between March and September 1979, we observed 479 initial hearings of respondents alleged to be dangerously mentally ill.[73] Two observers,[74] each using a detailed checklist,[75] independently recorded testimony and statements by lawyers and judges during each hearing. Checklist items were supplemented by note taking of relevant statements and behaviors. Following a day in court, the observers discussed each case to make sure both checklists covered every statement. Additionally, the investigators interviewed each lawyer on the day of hearing concerning his preparation for each case.[76] Six months after the court observation period ended, we interviewed by telephone or in person the same attorneys and judges concerning their views of counsel's role.[77]

STATED VIEWS OF COUNSEL'S ROLE

Table 1 presents proposed statements on counsel's role in civil commitment, to which attorneys and judges were asked to respond.[78] Generally, attorneys in North Carolina preferred the paternalistic model in civil commitment proceedings. They agreed overwhelmingly with the statement, "Representing respondents in civil commitment cases should be different from representing other kinds of clients since hospitalization may be in the best interest of the client." Similarly, the lawyers tended to disagree with the statement, "The role of the attorney in the civil commitment process should be the

73. The larger study included cases of dangerous mentally ill respondents who had had no hearings, and of dangerous inebriate respondents whose cases were divided both with and without hearings. Respondents who were found not to meet the commitment criteria often were released before their scheduled hearings, and the court dismissed their cases without holding any hearings. Inebriate respondents are handled differently by state mental hospitals and the courts. Generally they are detoxified and then released or recommended for release by psychiatrists because they no longer meet the dangerousness criterion (defined in N.C. Gen. Stat. § 122-58.2(1) (1981)). In some courts, the only inebriate respondents who have hearings are those whose families come to court and insist that they be involuntarily hospitalized. V. Hiday & S. Markell, Components of Dangerousness: Legal Standards in Civil Commitment, 3 Int'l J.L. & Psychiatry 405 (1981).

74. Sickness, death and coding errors took a toll of 3 attorneys and 2 judges, leaving a sample of 44 judges and 58 attorneys. On a few occasions, schedule conflicts prevented the research group from sending two observers. The one observer who attended in those few cases was an experienced faculty researcher.

75. A copy of the checklist can be found in the Appendix, infra.

76. Because of limited time between hearings in some courts, some lawyers were reached by telephone after the day of hearings. Because Special Counsel represented so many respondents in a single day and because they prepared for all cases in essentially the same manner, we sampled Special Counsel's cases for their prehearing behavior and generalized to all their cases rather than questioning them on every specific case.

77. Counsel outside of State mental hospitals tended to be young, recent law school graduates, with limited experience in involuntary civil commitment. Mean age was 34 years, with a range from 24 to 56 years. Seventy-five percent were under 35 years of age and had been in practice seven years or less. Mean years of practice was 6.25. Experience with civil commitment cases was even more limited, with most having handled fewer than seven such cases. Counsel in state mental hospitals (Special Counsel) also tended to be young (average age 29.6 years) and in practice a short time (average 3.3 years), but they were quite experienced with civil commitment cases, having dealt with hundreds of them prior to our study.

78. These statements are modified versions of statements used in an Iowa study. See Iowa Project, supra note 9, at 1447-52.

same as in a criminal case, that is, directed toward getting the least restrictive alternative possible for one's client, which includes avoiding confinement." There was, however, a sizeable minority who disagreed with the first statement and agreed with the second statement, indicating that these lawyers preferred an adversarial role. A few attorneys stated that they took a middle position and could not agree or disagree with these statements. They presumably would handle each case differently depending on their judgment of the case. Another group of attorneys indicated that they too were in a middle ground or were ambiguous about their role since they agreed with the first statement and also agreed with the second statement.[79]

A majority agreed with the third statement, that "[t]he role of the attorney in civil commitment cases should be to raise all relevant evidence about the respondent, that is, present both sides so that the court can decide." In their responses to this statement, attorneys once again indicated that they should not assume an adversarial role in civil commitment. Since most judicial districts do not provide an attorney to represent the interests of the state or petitioner, there is no counterbalance to an aggressive role by respondent's counsel. One might infer that attorneys choose the paternalistic model as opposed to an adversarial one because of this lack of balance, but the choice of role is not so simple. In those judicial districts employing legal representation for the State/petitioner, attorneys[80] were more likely to prefer an adversarial role, agreeing with the statement that their role should be the same as in a criminal case; but even in those districts, three-fifths agreed with the first statement, that their role is different in civil commitment because hospitalization may be best for a client. Fewer of them agreed with the third statement, that counsel's role is to raise all relevant evidence so the court can decide; but still the proportion agreeing represents half of all such attorneys.[81] It appears that an adversarial role is not clearly adopted by attorneys who face opposing counsel.

Judges were more likely than attorneys to prefer the paternalistic model, as they were approximately twenty percent more likely to favor the first statement and to disagree with the second statement. Judges also were more likely to agree with the third statement, that an attorney should present both sides so that the court can decide. Less than twenty percent of judges demonstrated approval of the adversarial model by disagreeing with the first statement and agreeing with the second statement; but more (almost one-third) disagreed with the third statement, that the lawyer should present both sides. In those judicial districts with legal representation for the State/petitioner, a higher proportion of judges supported an adversary model, agreeing that counsel's role was the same as in a criminal case and disagreeing that representing respondents in civil commitment should be different from representing other kinds of clients; however, these proportions still represent only a minority (less

79. Table 1, Appendix infra.

80. There were twenty attorneys in this group.

81. That is, 10 attorneys out of the 20 attorneys in this group.

than one-third each).[82] Hence, even in courts with lawyers representing both sides, judges tend to take a beneficent view of civil commitment and prefer the paternalistic model for the role of counsel.

To attempt to find one underlying value that would explain the choice of role model, we posed three other forced-choice statements. These statements attempted to ascertain whether attorneys and judges view the commitment process as a medical matter or a legal matter (Table 1). Responses to the statement that taps the question directly, the fourth statement, show attorneys fairly evenly split, with one-third each saying that it is more a legal matter/problem, that it is more a medical problem, and that it is equally a legal and medical problem. Judges were less likely to say it is more a legal problem (16.3 percent) and more likely to say it is both (58.1 percent). When asked to respond to the proposition that counsel's role should be secondary to the psychiatrist's (the fifth statement), however, almost two-thirds of both counsel and judges disagreed with the statement. Although approximately one-third in each group agreed, responses to this statement hardly indicate that attorneys and judges are willing to turn the procedure over to psychiatrists. This fifth statement provoked many in our sample to react negatively to the idea of a lawyer's role being secondary to anyone. Those seemed to be "fighting words" that obtained the strongest reaction from both attorneys and judges to any statement on counsel's role.[83] If this were not indicative of support for an adversarial role, responses to this statement would seem to indicate preference for a role independent of psychiatry in which counsel and court would decide respondents' best interests.

A majority of attorneys (58.6 percent) disagreed with the sixth statement, "When an attorney can see that a respondent is sick, he should not argue for release of the respondent," thus indicating their view that commitment is more than a medical matter. This is a surprisingly small majority, however, given that the law states that a respondent must be not only mentally ill but also dangerous to be committed. Despite the law, judges tended to agree with this statement. Only 37.2 percent of judges disagreed with the sixth statement, while 46.5 percent of them agreed.[84] One might infer that those who agreed with this statement do not understand the law or that their strong paternalistic concern for the mentally ill overrides their concern for civil liberties.

Responses to the last three statements in Table 1 imply that a significant percentage of both judges and attorneys adhere to a *parens patriae* foundation of civil commitment. Many view it more as a medical than as a legal problem, seeing counsel's role as secondary to the psychiatrist's and opting for a nonadversarial stance when mental illness is present. At the same time, another significant percentage seems to take a legal view of civil commitment and see counsel as primary in the process. This view is not opposite to the first

82. There were 20 judges from judicial districts with legal representation for the State/petitioner. Fewer than seven of these judges supported an adversarial model.

83. Table 1, Appendix infra.

84. Id.

because it could still represent a paternalistic stance; that is, counsel would decide what is best for the client and act to obtain it. The difference is that the paternalism in this case would be counsel's deciding the necessity of commitment rather than counsel's deferring to the psychiatrist's decision. Another significant percentage of judges and attorneys are in the middle, apparently seeing civil commitment as a problem that is equally legal and medical. The positions of all three groups are compatible with the paternalistic model of counsel's role for which the majority showed preference in their responses to the first three statements.

COUNSEL'S BEHAVIOR

Because what a person says and what he does are not necessarily congruent, we obtained behavioral measures of counsel's role as well as their stated views of that role. These measures are divided into two groups—behavior in court and behavior in preparation for court. We also divided attorneys into two groups—(a) Special Counsel (State-employed) and (b) all others (outside counsel), most of whom are appointed. Public defenders and a few privately retained counsel are included in the latter category.

Table 2 presents the objective measures of counsel's behavior in court. The major observation from this table is the infrequency with which either type of counsel was active. Outside counsel challenged the written medical report on the basis of inadequate facts of mental illness or imminent danger—facts required by law on the physician's affidavit—in only 4.7 percent of cases. In the other 95.3 percent, outside counsel either stipulated to the medical report or said nothing. Challenges to the medical reports were rare even though the reports frequently did not contain the required facts indicating mental illness or dangerousness (22.1 percent).[85] Failure to record appropriate facts on the medical affidavit, as well as failure to follow any other required procedure, can be cause for dismissal of the action. A few attorneys stated that they almost always could obtain a respondent's release because some requirement was not followed, such as inadequate facts in support of mental illness in the physician's affidavit or in the petition; however, in only 11.6 percent of cases did outside counsel argue for dismissal.[86]

Outside counsel almost never argued that the respondent was not mentally ill (2.3 percent). Attorneys in this group were more likely to argue that the dangerousness criteria were not met because the respodent was not dangerous at all or that the danger was not imminent (11.6 percent). In 18.6 percent of cases, outside counsel requested release or an alternative to commitment for the respondent. In 3.5 percent of cases, respondents' representatives pointed

85. The physician's affidavit form has a blank space for "facts indicating mental illness" and another blank space for "facts indicating dangerousness." In 5.0% of all cases, facility psychiatrists wrote nothing in either of the two appropriate spaces on the official form; in 0.4% they wrote only a diagnosis; in 0.5% they wrote facts, such as "cannot sleep at night," that did not indicate mental illness or dangerousness; and in 16.2% they failed in one of these ways to write the required facts in only one of the appropriate spaces.

86. Table 1, Appendix infra.

out the positive characteristics of the respondent that indicated capacity to live safely outside the hospital. In very few cases (1.2 percent) did outside counsel point out the negative aspects of hospitalization, or ways in which the respondent might be adversely affected by commitment; in the same low percentage of cases lawyers argued that conflicting testimony acted to nullify the alleged mental illness or dangerousness alleged in the petition.[87]

On the other hand, outside attorneys were active in admitting mental illness and imminent danger in 3.5 percent of cases, requesting commitment in 8.1 percent of the cases, and pointing out the hospital's positive aspects in 2.3 percent of the cases. In an additional 14.0 percent of cases they stated that the respondent wanted to go along with the physician's recommendation of involuntary commitment. In most cases, however, outside counsel made none of these arguments.[88]

Special Counsel generally showed a greater tendency toward activity, but for none of the measures was the difference between counsel types significant. These State-employed attorneys reported that often they did not challenge the medical report because the judge would have summoned the facility psychiatrist, who would have given testimony more damaging to the respondent than what was written in the legal record. Thus, apparent passivity actually may have been contrived silence, a tactic used by some special counsel to obtain release or a less restrictive alternative. In only 6.6 percent of the cases did Special Counsel state that the respondent was willing to follow the doctor's recommendation of commitment, and attorneys in this group requested commitment for their clients in less than 1.0 percent of cases.[89]

Besides making direct arguments to court, counsel may be active by challenging adverse testimony that fails to meet appropriate evidentiary standards. In only 15.8 percent of cases did outside counsel object to conclusory or irrelevant statements or to hearsay. We did not attempt to code the incidence of witnesses giving this testimony because it would have required a level of expertise in trial advocacy available only to experienced trial attorneys and not possessed by our observers. We cannot say how often in noncommitment cases this type of evidence is admitted without objection by counsel.[90] In some cases the judge or attorney for the State/petitioner(s)[91] prevented the testimony from coming into evidence even when counsel for respondent did not.[92] Special Counsel objected to hearsay or irrelevant or conclusory state-

87. Id.

88. Id.

89. Id.

90. A better measure of counsel's activity would be the proportion of proper objections made out of all cases in which an objection should have been made. Lacking training and experience in litigation, the team declined to make such an assessment.

91. Only three counties (Cumberland, Forsyth and Macon) other than counties with state mental hospitals provided legal representation for the State/petitioner.

92. If the attorney for the State/petitioner or the judge did not allow irrelevant, hearsay or conclusory statements to enter into evidence, then counsel would not have to object. In most civil commitment courts that we observed, however, all three types of statements appeared to have been made frequently.

ments almost twice as often as outside counsel (31.7 percent to 15.8 percent).[93]

Many witnesses, especially those of lower socio-economic status,[94] did not present clear, cogent and convincing evidence necessary to show facts of mental illness and imminent danger. They frequently made general statements without giving specific facts. If appropriate factual evidence on which the court can make a decision about commitment is to be presented, then respondent's counsel, counsel for the State/petitioner, and often the judge, generally must question witnesses about the specific acts, timing, or circumstances of the allegedly dangerous behavior. In 55.3 percent of cases, outside counsel questioned witnesses on the specific allegedly dangerous behavior, on the timing of that behavior or on the circumstances surrounding it. Special Counsel did so in 44.1 percent of cases. Both types of counsel showed more activity on this measure than on other measures. Even here, however, in nearly half the cases outside state mental hospitals and in over half of those within state mental hospitals, counsel for respondent was not active.[95]

Table 3 presents the behavior of attorneys in preparation for their cases in court as reported by the attorneys themselves. From our observations, it is clear that prior to the hearing, outside counsel usually read the legal record, which typically consisted of the petition, one or two physical affidavits and an indigency report. Preparation in other ways left much to be desired, as can be seen in Table 3. Outside attorneys either did not speak with their clients, or spoke with them only a few minutes before hearings, in 39.5 percent of cases. The 60.5 percent who did speak with their clients more than a few minutes prior to hearings represents an improvement over the general lack of discussion with respondents reported in previous studies.[96] All of these discussions between the outside counsel and respondent client took place in person. Mean time spent with client was 15.9 minutes, with a range of 1.0 minute to 4.5 hours. Forty-two percent spoke for ten minutes or less, and 87 percent spoke for 30 minutes or less.

Outside counsel's preparation for hearings was even less adequate when measured by attempted fact-finding from persons other than the respondent. In only 16.0 percent of cases did outside counsel speak with petitioner(s); in only 15.6 percent did outside counsel speak with facility psychiatrists who

93. Table 2, Appendix infra.

94. Most civil commitment respondents in our sample, as well as most patients admitted to state mental hospitals, were members of the lower socioeconomic class. Sample mean monthly income was $202 for those whose record contained income information; and over two-thirds had a monthly income of $250 or less, with just over 14% having no income. Seldom do middle class or upper middle class persons become respondents to involuntary commitment proceedings. Only eleven respondents had reported monthly incomes of over $500, and of those without income information, only 3.1% could be classified as upper middle class on the basis of speech, dress, education or occupation of either themselves or their families. One-fourth of all witnesses were respondents. Parents, children and spouses represented 31% of witnesses; and other relatives, friends and neighbors represented 14% of witnesses. The majority of witnesses, thus, were lower class.

95. Table 2, Appendix infra.

96. Andalman & Chambers, supra note 9, at 55-72; Cohen, supra note 9, at 428; Dix, supra note 24, at 9-10; Special Project, supra note 9, at 32-33, 38-60; Contemporary Studies Project, supra note 15, at 913-16.

were giving the expert opinion and recommendation to commit; and in only 8.9 percent did the attorneys speak with any other witnesses. In sum, outside attorneys were not active in preparation for civil commitment cases.

Special Counsel, in contrast, always spoke with respondents in person prior to the day of hearing. Mean time with clients was longer—22.2 minutes, with a range of 2 to 45 minutes. State-employed attorneys were more likely to speak with clients prior to hearings because thejr law offices are located in the state mental hospitals and because their entire practice consists of representing involuntary commitment respondents.

Lack of proximity to respondents was a problem for outside counsel particularly when there was a change of venue. In that situation the respondent was brought to the county of petition immediately prior to the hearing. In only one-third of these cases did outside counsel speak to respondents ahead of time. Many outside attorneys cited the low per-hour payment of court-appointed attorneys as the explanation. They argued that, at thirty-five to fifty dollars per case, a lawyer could not afford to drive one hour or more each way to the state hospital to interview a respondent prior to his hearing. (Some trial judges in fact paid outside counsel more per case.) Nonetheless, even when respondents were being held in the county of hearing, outside attorneys did not speak with their clients in 38.1 percent of the cases. Outside court-appointed attorneys again generally claimed they could not afford the time to drive to the local hospital for an in-person interview. Unlike other cases, in which the telephone is used extensively for exchanges with clients, telephoning was apparently discounted as a method of gaining information from a mental commitment respondent. Attorneys either assumed irrationality on the part of these clients, felt an inability to discern a client's mental status over the telephone, or thought the telephone inappropriate for initial conferences with unknown persons who might be irrational or suspicious.

Special Counsel's location also affected the attorney's ability to find facts from persons other than the respondent. In 65.5 percent of cases, State-employed attorneys talked with psychiatrists, and in almost all cases (92.9 percent) they spoke to psychiatrists or staff. Often nurses were used as informational sources instead of psychiatrists. Special Counsel indicated that nurses' daily contact with respondents gave them more knowledge than psychiatrists who saw respondents approximately once a week.

Special Counsel, however, did attempt negotiations with psychiatrists in a substantial number of cases. When psychiatrists initially recommended commitment (52.4 percent of all cases), Special Counsel attempted to persuade them to recommend release or an alternative in 38.1 percent of the cases. Of the 70.4 percent of cases in which Special Counsel talked with psychiatrists, the attorneys tried actively to negotiate 62.5 percent of the time. State-employed attorneys in civil commitment cases generally plea bargain with the psychiatrist in the same manner that criminal defense attorneys bargain with the prosecutor. Psychiatrists may be medical professionals, but their role in civil commitment is similar to the prosecutor's because they can drop, reduce

or advance charges of mental illness and imminent dangerousness. Similarly, they can recommend release, less restrictive alternatives or commitment.[97] Plea bargaining was a frequent tactic of Special Counsel, often resulting in a psychiatrist's recommendation of release or a less restrictive alternative that the court generally approved. Outside counsel seldom even spoke with psychiatrists, and plea bargaining is evidently not a favorite tool of outside counsel; bargaining was attempted in only 27.3 percent of the 15.6 percent of cases in which outside counsel spoke with the psychiatrist.[98]

Special Counsel spoke with petitioners in only 5.0 percent of cases. This was partly a problem of making long-distance contact. Attorneys in this group also reported that often they did not want to talk with petitioners because adverse testimony at the hearing would be more likely if they reminded petitioners of hearings. At other times when petitioners felt that respondents had improved and could come home, Special Counsel wanted them to testify. One attorney said he never contacted petitioners because he did not want to be in the position of pressuring the State's witnesses. Overall, Special Counsel were active in preparation for civil commitment hearings, particularly when compared with outside counsel.[99]

Preparation of most outside counsel falls short of the basic preparation expected of a lawyer in any case, that is, interviewing the client and potential witnesses on all relevant facts and circumstances, with subsequent investigation of those facts.[100] Attorneys who did little to prepare for their cases often were embarrassed by our questioning of their preparation. Some became progressively hostile as each answer revealed that they had done nothing. Others became defensive, offering excuses for their lack of preparation such as: "They are crazy, so what good would it do to talk to them"; "I could tell from the record Mrs. *X* was mentally ill and dangerous so I didn't need to talk with anyone"; "We handle these cases no differently from (the way we handle) criminal cases: read the file just before court and talk to the defendant then."

The meager efforts of outside counsel to prepare for their cases belie their stated paternalistic view of counsel's role in civil commitment and their opinion that counsel's role should not be secondary to the psychiatrist's. One cannot play a primary role and represent a respondent's best interests (however interpreted) if he is uninformed or informed only by a single brief interview

97. One might argue that mental illness is not analogous to crime, thereby questioning the propriety of "plea bargaining" in civil commitment. Like crime, however, mental illness varies in its seriousness and level of offense. Similarly, it is the police power of the state that justifies confinement of the mentally ill who are dangerous to others. Furthermore, counsel has much leeway in negotiating with psychiatrists since indications of dangerousness are often inadequate. In witness testimony, 42% of the commitment cases had no evidence of assault, threat, property attack or unintentional harm (such as wandering in the middle of a busy street). See V. Hiday & S. Markell, supra note 73, at 410. See also note 85 supra, for inadequate indications of dangerousness and mental illness on the psychiatric affidavit.

98. Table 3, Appendix infra.

99. Id.

100. Model Code of Professional Responsibility EC 6-4 (1979) states that "[an attorney's] obligation to his client requires him to prepare adequately for and give appropriate attention to his legal work."

with his client and a reading of the official record. Most respondents have limited verbal ability[101] and are often medicated to the point of slow thought, speech and movement at the time of the interview;[102] official records often do not fully describe behavior indicative of mental illness and dangerousness, much less describe extenuating circumstances;[103] and psychiatrists often rely on what is written in the petitions for evidence of dangerousness.[104] Therefore, an attorney needs to do more than read official records and talk briefly with clients if he is to represent the best interests of civil commitment respondents.

EFFECTS ON COMMITMENTS

Given outside counsel's poor preparation and inactivity in court, one might expect that many respondents who do not meet the substantive criteria for involuntary hospitalization would be committed to North Carolina mental hospitals. This, however, is not the case. Although attorneys appear to be deferring to psychiatric opinion by their behavior in and out of court, judges do not follow suit. When lawyers are passive, judges often question witnesses about specific, allegedly dangerous acts, their timing and circumstances; thus, they act to bring forth evidence concerning imminent[105] dangerousness[106] or the lack thereof. Furthermore, judges do not commit respondents to involuntary hospitalization without at least a preponderance of evidence of imminent dangerousness.[107] We observed only sixteen hearings in which respondents were committed with less than a preponderance of evidence of acts or threats

101. This conclusion is based on observations of respondents' testimony in court.

102. The extent of medication was evident from observations of respondents in court and from statements by Special Counsel and judges. One respondent told her attorney that she had been walking the halls for an hour prior to coming to court in order to fight the grogginess induced by medication. She was afraid that her slow responses would be interpreted by the court as evidence of mental illness.

103. See note 85 supra.

104. Much allegedly dangerous behavior of involuntary civil commitment respondents occurs in the community prior to examination by a physician. Since the psychiatrist's job does not include tracking down witnesses to acts occurring outside the hospital, he must trust what others tell him for indications of dangerousness.

105. At the time of this study, one statutory criterion was still "imminently dangerous" instead of simply "dangerous" as it is now. See note 69 supra.

106. Hiday, Court Decisions in Civil Commitment: Independence or Deference?, 4 Int'l J.L. & Psychiatry 159 (1981).

One case observed by the author depicts an extreme example of a judge's having to question witnesses when counsel failed to do so. Appointed counsel stated at the beginning of a hearing that the respondent acknowledged his mental illness and was willing to follow the psychiatrist's recommendation of involuntary hospitalization. When the judge asked the respondent if this were true, and the respondent answered in the negative, the judge asked the respondent to take the witness stand. Hearing no evidence of dangerousness and having no other potential witness present, the judge phoned the respondent's psychiatrist and requested his appearance. It was only after the judge questioned the psychiatrist on the witness stand and obtained behavioral evidence of the respondent's dangerousness that he committed the respondent.

107. The North Carolina statute reads: "To support a commitment order, the court is required to find, by clear, cogent, and convincing evidence, that the respondent is mentally ill or inebriate, and dangerous to himself or others, or is mentally retarded, and because of an accompanying behavior disorder, is dangerous to others." N.C. Gen. Stat. § 122-58.7(i) (1981).

that could cause substantial physical harm.[108]

Despite judges' preference for a paternalistic role of counsel and their apparent reliance on the *parens patriae* foundation of civil commitment, judges are not deferring to psychiatrists. Rather, they are insisting on behavioral evidence of imminent dangerousness before ordering involuntary hospitalization. If their beneficent view of civil commitment is not influencing them to defer to psychiatric opinion, as it has done in other states, what is influencing North Carolina judges in their decisions? One explanation may be that district court judges are sensitive to being reversed; the North Carolina Court of Appeals has reversed a number of district commitment decisions that were not based on behavioral evidence of imminent dangerousness.[109]

We thus come full circle to the role of counsel, because attorneys representing civil commitment respondents have brought these cases to the North Carolina Court of Appeals. Some of these cases are appeals brought by Special Counsel.[110] While most attorneys do not assume an adversarial stance in civil commitment, enough do act as advocates to sensitize judges to follow a legal model rather than a medical model regardless of the behavior of the individual attorneys in their districts.

CONCLUSION

While diagnosis and treatment of mental illness may be a medical problem properly entrusted to those with psychiatric expertise, the decision to force a person to be treated in a mental hospital is a legal matter because it employs the coercive powers of the state to deprive an individual of his liberty. The attorney who focuses on the *parens patriae* foundation for civil commitment overlooks the deprivation of freedom involved in these proceedings. He also overlooks other deprivations that accompany involuntary placement in a mental hospital. A commited person loses his right to privacy because he is under constant observation by both hospital staff and other patients; he may lose his autonomy through compulsory medication and other intrusive treatment. A committed person may be subjected to a hospital that is inadequately staffed, overcrowded, unsanitary, deplorably maintained and unable to offer protection from the brutality of patients and attendants.[111] A committed person suffers the social stigma of being a hospitalized mental patient, and worse, one who has been found dangerous enough to be forcibly hospitalized. This

108. As determined by criteria set forth in Hiday, supra note 106, at 166.

109. E.g., In re Doty, 38 N.C. App. 233, 247 S.E.2d 628 (1978); In re Hogan, 32 N.C. App. 429, 232 S.E.2d 492 (1977); In re Weatherly, 28 N.C. App. 659, 222 S.E.2d 486 (1976); In re Carter, 25 N.C. App. 442, 213 S.E.2d 409 (1975).

110. E.g., In re Doty, 38 N.C. App. 233, 247 S.E.2d 628 (1978).

111. See J. Robitscher, The Powers of Psychiatry (1980); Rosenhan, On Being Sane in Insane Places, 179 Sci. 250 (1973); Sheehan, The Patient: Creedmore Psychiatric Center (pt. 1), New Yorker, May 25, 1981, at 49; Developments in the Law, supra note 13, at 1197; Citron, Century of Shame (pt. 1), Times-Picayune (New Orleans), Aug. 17, 1980, at 1, col. 1.

For judicial descriptions of poor conditions in mental hospitals, see Wyatt v. Aderholt, 503 F.2d 1305, 1310-12 (5th Cir. 1974); New York State Ass'n for Retarded Children v. Rockefeller, 357 F. Supp. 752, 756 (E.D.N.Y. 1973).

stigma also may involve more serious long-term consequences, such as the inability to obtain employment. Attention to the negative consequences of involuntary hospitalization may undermine the attorney's view of civil commitment as beneficent.[112]

Knowledge of the conditions under which institutional psychiatrists make their diagnoses and predictions might move attorneys towards an active, if not an adversarial, role.[113] Psychiatrists in chronically understaffed state hospitals are able to spend only minimal time with respondents.[114] Their examinations of respondents tend to be brief, and they rely heavily on reports of other staff in forming their diagnoses and final recommendations. For indications of dangerousness, they often rely solely on behavior described in written petitions. Since most allegedly dangerous behavior occurs in the community, psychiatrists are unable to observe signs of dangerousness. Having neither time nor training to investigate the petitioners' allegations, psychiatrists trust the truth and accuracy of those allegations and use them in making recommendations to the court.[115] Attorneys who defer to psychiatrists are thus relying on opinions based on hearsay.[116] An annoying, eccentric individual with non-

112. See generally Developments in the Law, supra note 13.

113. One experimental study in Austin, Texas, suggests that knowledge of conditions may make no difference in counsel's role. A small sample of attorneys was given three hours of training in coping with psychiatric testimony. The attorneys also received a letter from the chief judge that stated that the commitment proceeding was adversarial and that the state had the burden of proof. The "trained" lawyers behaved no differently in civil commitment proceedings than did a control group of untrained attorneys. Both groups frequently prejudiced the evidence and did little to prevent their clients' involuntary hospitalization. The researcher felt that "the altruistic motive to see that a perceived sick person get treatment dominates their behavior." The sample was extremely small, and the researcher did not reveal details concerning the training. Thus, one should be skeptical about making any generalizations. N. Poythress, Psychiatric Expertise in Civil Commitment: Training Attorneys to Cope with Expert Testimony, 2 Law & Hum. Behav. 1 (1978).

114. Rosenhan, supra note 111.

115. Hiday, supra note 106, at 163 n.7.

116. Even worse is the case of relying on the opinions of physicians from less developed countries, who comprise a significant proportion of physicians at state mental hospitals throughout the United States. See generally D. Light, Becoming Psychiatrists (1980). Their diagnoses and recommendations can be based on total misrepresentations of respondent's visible behavior and statements because of the great cultural and language barriers that exist. Moreover, physicians whose English cannot easily be understood aggravate the cultural barriers and handicap respondents in their attempts to provide meaningful responses to physicians' questions. For instance, we observed one foreign psychiatrist who could not be understood even after being asked to repeat his responses to questions several times. After he left the courtroom, one attorney said, "He's a great psychiatrist; he just can't speak English." For a graphic description of the mistakes that can be made when culture and language bar intelligent communication between patients and psychiatrists from less developed countries, see Sheehan, supra note 111.

Another problem involving both American and foreign psychiatrists occurs when diagnoses and recommendations are biased in terms of race, sex, age, class, values and prior hospitalization. See Blake, The Influence of Race on Diagnosis, 43 Smith C. Stud. Soc. Work 184 (1973); Frank, Psychiatric Diagnosis: A Review of Research, 81 J. Gen. Psychiatry 157 (1969); Lewinson & York, The Attribution of "Dangerousness" in Mental Health Evaluations, 15 J. Health & Soc. Behav. 328 (1974); Mendel & Rapport, Determinants of the Decision for Psychiatric Hospitalization, 20 Archives Gen. Psychiatry 321 (1969); Schwartz & Abramowitz, Values-Related Effects on Psychiatric Judgment, 32 Archives Gen. Psychiatry 1525 (1975); Shader, Binstock, Ohly & Scott, Biasing Factors in Diagnosis and Disposition, 10 Comprehensive Psychiatry 81 (1969). For a general review of the literature on the validity and reliability of psychiatric diagnosis and predictions of dangerousness, see Ennis & Litwack, supra note 14.

psychotic mental problems, whose family wants to get rid of him in a mental hospital, may have no hope for maintaining his liberty unless counsel assumes a more skeptical view of each step in the commitment procedures. If the right to counsel is to have any meaning as a due process protection in civil commitment, counsel's role must include a thorough investigation of allegations in the petition and in the physician's report. This investigation requires counsel to interview respondents, petitioner(s), other witnesses, psychiatrists and respondent's family and friends.[117] If he finds the allegations untrue or inaccurate, or if he finds the psychiatrists without a solid basis for an opinion, he may take an adversarial stance rather than a paternalistic one in the commitment hearing.[118]

An adversarial stance would not necessarily mean that the attorney would argue for release of his client. Counsel could argue for a less restrictive alternative, such as voluntary hospitalization or outpatient treatment. The North Carolina statute encourages use of less restrictive alternatives[119] and provides a procedure for assuring that outpatient commitment orders are followed;[120] however, less restrictive alternatives, especially outpatient commitments, are used only infrequently. Courts tend either to commit respondents to involuntary hospitalization or to release them. In our sample of initial adult respondents, only 9.2 percent were ordered to less restrictive alternatives, and only 28.1 percent of those were ordered to outpatient commitment in community health centers.[121]

Many respondents need psychiatric help because of their mental illness, and a substantial proportion of these can be treated safely in the community. One study found only a sixteen percent failure rate among outpatient commitments to community mental health centers.[122] It should be noted that the study respondents who were committed to outpatient treatment were carefully screened by a psychiatrist, a lawyer and the court as good risks for a less restrictive alternative. If a component of legal representation is helping a client to avoid unnecessary involuntary hospitalization, counsel's role in civil commitment requires investigation of the availability of appropriate alternatives and exploration of their use with his clients and their psychiatrists. The truly paternalistic and adversarial roles both demand pursuit of less restrictive alternatives for clients.

Thorough investigation of allegations of dangerous mental illness and of

117. See note 94 supra.

118. Psychiatrists may also become more thoughtful and deliberate in handling civil commitment respondents when they have to face counsel's challenging questions. See Litwack, supra note 9, at 839.

119. N.C. Gen. Stat. § 122-58.1 (1981). See In re Farrow, 41 N.C. 680, 686, 255 S.E.2d 777, 782 (1979).

120. N.C. Gen. Stat. § 122-58.8(b), (c) (1981).

121. V. Hiday & R. Goodman, The Least Restrictive Alternative to Involuntary Hospitalization, Outpatient Commitment: Its Use and Effectiveness (unpublished manuscript).

122. Failure is measured by respondents' becoming dangerous or not following commitment orders and thus having to be involuntarily hospitalized within ninety days of the issuance of their orders. Id. In North Carolina, initial commitment for inpatient or outpatient treatment is limited to "a period not in excess of 90 days." N.C. Gen. Stat. § 122-58.8(b) (1981).

less restrictive alternatives requires time, much more time than that expended by most appointed counsel and public defenders in civil commitment cases. Appointed counsel, however, are not likely to spend more time without greater reimbursement for their efforts.[123] Given the general cutback of government spending in today's economy, increased funding for appointed counsel is unlikely. Furthermore, this funding would not affect public defenders who are paid fixed salaries. Some states have tried legislating counsel's duties to require a thorough investigation,[124] but no studies have reported whether these efforts have been successful.

Several legal scholars argue that adequate legal representation requires full-time civil commitment advocates who have the time, expertise and dedication to represent adequately the rights of the poor and dispossessed who comprise the overwhelming majority of respondents.[125] We have seen that the full-time counsel at North Carolina state mental hospitals prepare for their cases and seek alternatives to involuntary hospitalization. Since approximately eighty percent of respondents in North Carolina are processed through courts at state mental hospitals,[126] they have the benefit of full-time civil commitment advocates. The other twenty percent have their hearings in courts located either in the county of petition, when they request a change of venue, or in the county in which they are hospitalized.[127] The cost of full-time civil commitment advocates for this twenty percent would be prohibitive given the wide distribution of cases throughout the state and given the time limitation on hearings.[128]

Although full-time civil commitment advocates have brought time, expertise and dedication to representation of civil commitment respondents, they have not all chosen an adversarial role for all cases. The question whether counsel should assume an adversarial or a paternalistic role is essentially a question of society's values. Does society wish to err on the side of individual freedom—is it willing to release some dangerously mentally ill persons in order to ensure that no person who is not dangerous or not mentally ill is incarcerated? Or does it wish to err on the side of protection—is it willing to allow some nondangerous or non-mentally ill persons to be hospitalized involuntarily rather than risk an individual's harming others or himself? In the area of criminal law, our society has opted for protection of individual freedom, and

123. Andalman & Chambers, supra note 9. One should remember that only a small proportion of outside counsel currently are giving the time necessary to fully investigate civil commitment cases despite low reimbursement.

124. For instance, Arizona requires that counsel conduct an interview of the patient within 24 hours of appointment. At least 24 hours before the hearing the attorney must review the applicable paperwork and conduct interviews of the petitioner, the supporting witnesses and the physicians who will testify at the hearing. Failure to comply is punishable by contempt. Ariz. Rev. Stat. Ann. § 36-537 (Supp. 1981-82).

125. See Litwack, supra note 9, at 839. See also Andalman & Chambers, supra note 9 at 80-82.

126. See Hiday, supra note 106, at 161.

127. Id.

128. The hearing must be held within ten days of the respondent's being taken into custody. N.C. Gen. Stat. § 122-58.7(a) (1981).

counsel has clear direction to follow an adversary role. In the area of civil commitment, our society has not made the value judgment. The choice currently is left to counsel.

APPENDIX

Table 1

RESPONSES TO STATEMENTS ON ROLE OF COUNSEL

Statement	Response	Counsel (N=58) %	Judges (N=44) %
1. Representing respondents in civil commitment cases should be different from representing other kinds of clients since hospitalization may be in the best interests of the client.	Agree	65.5	81.4
	Middle	3.5	0.0
	Disagree	31.0	18.6
2. The role of the attorney in the civil commitment process should be the same as in a criminal case, that is, directed toward getting the least restrictive alternative possible for one's client, which includes avoiding confinement.	Agree	41.4	18.6
	Middle	1.7	4.7
	Disagree	56.9	76.7
3. The role of the attorney in civil commitment cases should be to raise all relevant evidence about the respondent, that is, present both sides so that the court can decide.	Agree	55.2	60.5
	Middle	1.7	7.0
	Disagree	43.1	32.5
4. Do you think civil commitment is more a legal or a medical problem (matter)?	Legal	39.3	16.3
	Both	30.4	58.1
	Medical	30.4	25.6
5. The role of the attorney in the civil commitment process should be generally secondary to that of the psychiatrist who must determine whether or not a person is mentally ill and dangerous.	Agree	29.3	34.1
	Middle	5.2	4.5
	Disagree	65.5	61.4
6. When an attorney can see that a respondent is sick, he should not argue for release of the respondent.	Agree	27.6	46.5
	Middle	13.8	16.3
	Disagree	58.6	37.2

Table 2

STATEMENTS IN COURT BY TYPE OF COUNSEL

	Outside Counsel	Special Counsel
N of cases	86	368
Against Commitment	%	%
Challenge medical report	4.7	6.3
Ask dismissal	11.6	15.8
State no mental illness	2.3	3.3
State no danger, danger not imminent	11.6	14.1
Ask release/alternative	18.6	20.9
State respondent's positive traits	3.5	1.1
State negative aspects of hospitalization	1.2	1.4
Point out conflicting testimony	1.2	0.5
Object to hearsay, irrelevant or conclusory statements*	15.8	31.7
Question acts, timing or circumstances*	55.3	44.1
Supporting Commitment	%	%
State mental illness and imminent danger	3.5	0.0
Ask commitment	8.1	0.8
State willingness to follow MD's recommendation of commitment	14.0	6.5
State respondent's negative traits	0.0	0.0
State positive aspects of hospitalization	2.3	0.0

*N of outside counsel cases drops to 76 and N of special counsel cases drops to 281 because of a loss of cases without witness testimony.

Table 3

PREPARATION IN CIVIL COMMMITMENT CASES BY TYPE OF COUNSEL

	Outside Counsel	Special Counsel
N of cases	81	368
Speak with client	60.5%	100.0%
in person	100.0%	100.0%
$\bar{\chi}$ time in minutes	15.9 mins.	22.2 mins.
Speak with petitioner(s)	16.0%	5.0%
Speak with psychiatrist	15.6%	70.4%
try to persuade	27.3%	62.5%
Speak with other witnesses	8.9%	42.3%

Checklist for North Carolina Study

FROM COURT HEARINGS:

Respondent's Court Number ____ Date of petition ____

County of petition: Name _____ Code _____

Male ____ Age ____ White ____ Black ____ Other ____
Female ____

Single ____ Rural ____ Own income $_____ monthly
Married ____ Urban ____ Spouse's income $_____ monthly
Separated ____ Metropolitan ____
Divorced ____
Widowed ____

Employed:
Yes ____
No ____

Indigent:
Yes ____
No ____

Petitioner:
Spouse ____
Child/parent ____
Other relative ____
Friend/neighbor ____
Law officer ____
Social Service ____
MD ____

Prior hospitalization:
No ____
Yes ____
Not mentioned ____

Prior dangerousness:
No ____
Yes ____
Not mentioned ____

Date, exam by local MD _____ Date, exam by hospital MD _____

Diagnosis (final):
None ____
Schiz. ____
Paranoia ____
Depression ____
OBS ____
Psychosis ____
Neurosis ____
Alcoholic ____
Other ____
NM ____

Psychiatric Recommendation:
Release ____
Commit outpatient ____
Voluntary ____
Commit hospital ____
Alternatives ____
Recommit ____
NM ____

Psychiatrist: Facts for mental illness or illness:
Nothing ____
Yes ____
No facts, only diagnosis ____

Psychiatrist: Facts for imminent dangerousness
Nothing ____
Yes ____
No facts, only diagnosis ____

Request for hearing in jurisdiction of petition?
No ____
Yes ____

Psychiatrist summoned? Yes ____ No ____

Number of witnesses summoned ____

HEARING:

Hearing date _____ Hearing order _____ Hearing County: Name _____
Code _____

Place: Hospital? Yes____ No____ Judge: Name _____ Code____

Counsel:
Name _____
Ct. appointed ____
Special counsel ____
Public defender ____
Private ____

Respondent waived presence:
No ____
Cannot communicate ____
Physically disabled ____
R. not want to appear ____
Other (what?) ____

Shoes ____
Slippers ____
Other ____

Street clothes ____
Bed clothes ____
Other ____

Height:
Less than 5'6" (short) ____
5'6" - 5'10" (med.) ____
Less than 5'10" (tall) ____

Mass:
Frail ____
Avg. ____
Muscular ____
Obese ____

Behavior:
Normal ____
Drowsy ____
Restless ____
Inattentive ____
Other (what?) ____

Beginning time ____
Ending time ____
Total time (in minutes) ____

COUNSEL'S SUMMATION:

Move for dismissal? Yes ____ No ____

Counsel argue no mental illness or inebriety:

Admits mental illness ____
Yes ____
NM ____

Counsel argue:
Admits imminent dangerousness ____
Dangerousness not imminent ____
Not dangerous now ____

Counsel ask:
Release ____
Outpatient treatment ____
Voluntary treatment ____
Involuntary commitment ____
Alternatives ____
(what?) _____

Counsel point out good points of Respondent:
Bad points ____
Yes ____
NM ____

Counsel point out negative aspects of hospitalization/commitment:

Good points ____ Yes ____ NM ____

ADVOCATE'S SUMMATION:

Advocate argues Respondent is mentally ill or ill:
Admits not ____
Yes ____
NM ____

Advocate argues:
Not imminently dangerous ____
Dangerous ____
Dangerousness is imminent ____
NM ____

Advocate points out positive aspects of hospitalization/commitment:
Admits bad ____
Yes ____
NM ____

Advocate points out no alternative:
No advocate ____
Yes ____
NM ____

Advocate points out negative effects of Respondent on family/friends:
Yes ____
NM ____

JUDGE'S STATEMENT:

Decision:
- Release ___
- Commit outpat. ___
- Alternatives ___
- (what?) ___
- Recommit ___
- Dismiss ___

Stated basis:
- Not stated ___
- Act/threats ___
- Medical record ___
- Diagnosis ___
- Social situation ___
- Other ___

Stated "No evidence but psychiatrist recommends":
- Yes ___
- NM ___

Respondent's Court Number ___

Evidence shows mental illness (other than just conclusion):
No ___ Yes ___ NM ___

Evidence shows dangerousness: No ___ Yes ___ NM ___

Evidence shows danger is imminent: No ___ Yes ___ NM ___

Conflicting testimony:
- No ___
- Events ___

Conclusions:
- Danger ___
- Imminence ___

If conflicting events—let panel of three judges decide and put blank at end for their consensus.

EACH WITNESS:

- Psychiatrist/MD ___
- Social Worker ___
- Police/sheriff ___
- Spouse ___
- Child/parent ___
- Other relative ___
- Friend/neighbor ___
- Other ___
- Respondent ___

Testimony of witness #____:

Physical attack:
- none ___
- to self ___
- to others ___
- to both ___
- NM

Frequency:
_____ (# of times)
NM ___

Recent:
_____ (days before hearing)
NM ___

Weapon:
- gun ___
- knife ___
- heavy instr. ___
- small instr. ___
- poison/drugs ___
- other ___
- what? ___
- NM ___

Severity:
- death ___
- maim ___
- req. med. attention ___
- minor cut/ bruises ___
- no phys. harm ___
- NM ___

Threats with action:
- none ___
- to self ___
- to others ___
- to both ___
- NM

Frequency:
_____ (# of times)
NM ___

Recent:
_____ (days before hearing)
NM ___

Weapon:
- gun ___
- knife ___
- heavy instr. ___
- small instr. ___
- poison/drugs ___
- other ___
- what? ___
- NM ___

Severity:
- death ___
- maim ___
- req. med. attention ___
- minor cut/ bruises ___
- no phys. harm ___
- NM ___

Threats, no action:
- none ___
- to self ___
- to others ___
- to both ___
- NM

Frequency:
_____ (# of times)
NM ___

Recent:
_____ (days before hearing)
NM ___

Weapon:
- gun ___
- knife ___
- heavy instr. ___
- small instr. ___
- poison/drugs ___
- other ___
- what? ___
- NM ___

Severity:
- death ___
- maim ___
- req. med. attention ___
- minor cut/ bruises ___
- no phys. harm ___
- NM ___

Property attack:
- none ____
- yes ____
- NM ____

Frequency: _____ (# of times) NM ____

Recent: _____ (days before hearing) NM ____

Means:
- fire ____
- heavy instr. ____
- small instr. ____
- other ____
- NM ____

Severity:
- no damage ____
- serious damage ____
- minor damage ____
- miniscule damage ____
- NM ____

Unintentional harm:
- none ____
- to self ____
- to others ____
- to both ____

Frequency: _____ (# of times) NM ____

Recent: _____ (days before hearing) NM ____

Means:
- wander ____
- fire ____
- heavy instr. ____
- small instr. ____
- other ____
- NM ____

Severity:
- no harm ____
- serious harm ____
- minor harm ____
- miniscule harm ____
- NM ____

Not eat/fix food ____
Not dress ____
Not housekeep ____
Not take medicine ____
Other, (what)?_____

Conclusory statement on danger or imminent dangerousness
- Not dangerous ____
- Is dangerous ____
- Is imminently dangerous ____
- NM ____

Diagnosis (including mental illness or illness)
- Not mentally ill/ill ____
- Is mentally ill/ill ____

Specific what?_____
- NM ____

Need for treatment:
- Not need ____
- Yes ____
- NM ____

Prior danger:
- No ____
- Yes ____
- NM ____

Prior hospitalization:
- No ____
- Yes ____
- NM ____

Counsel questions specific acts/words:
- No ____
- Yes ____

Counsel questions specific timing:
- No ____
- Yes ____

Counsel questions specific circumstances:
- No ____
- Yes ____

Counsel objects to hearsay/conclusory statements:
- No ____
- Yes ____

Advocate questions specific acts/words:
- No ____
- Yes ____

Advocate questions specific timing:
- No ____
- Yes ____

Advocate questions specific circumstances:
- No ____
- Yes ____

Judge questions specific: acts/words
- No ____
- Yes ____

Judge questions specific: timing
- No ____
- Yes ____

Judge questions specific circumstances:
- No ____
- Yes ____