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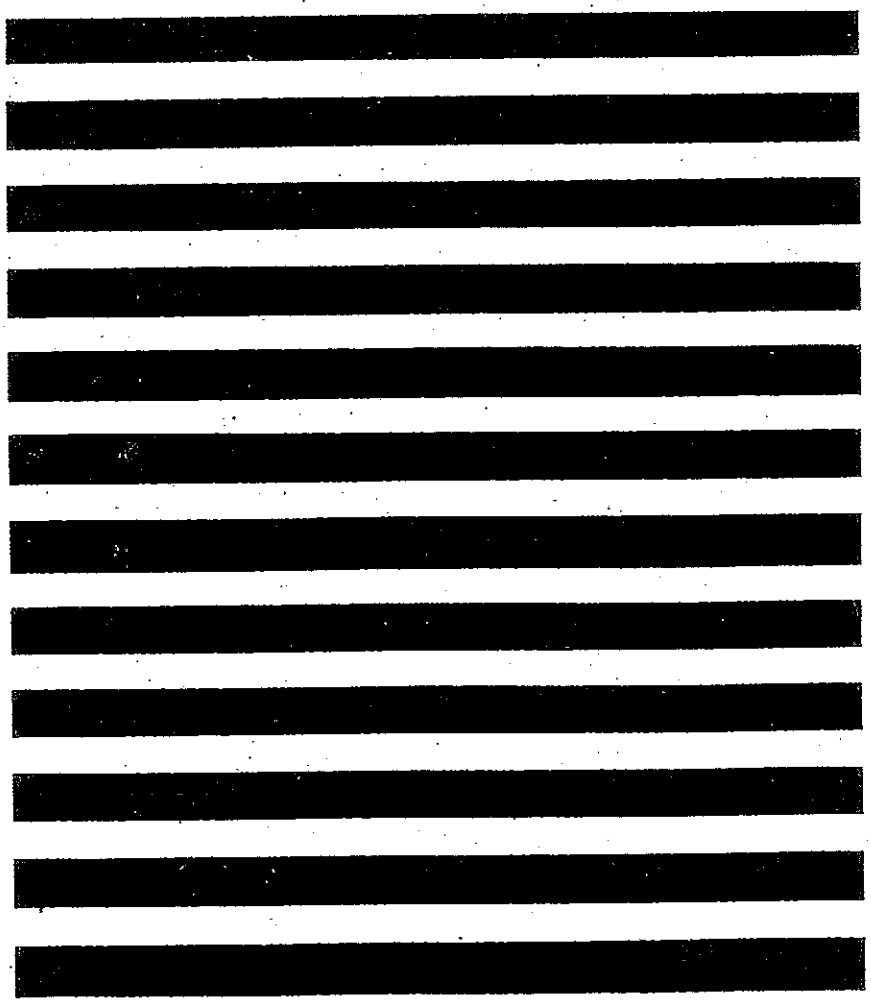

Mental commitments: the judicial function—a case perspective

BY PROFESSOR ARTHUR B. LAFRANCE

Professor LaFrance served as a circuit judge pro tempore *in a number of mental commitment proceedings in Oregon. He then observed several days of proceedings in Maine, for comparison purposes. Here he summarizes many of the Oregon and Maine cases, changing names of respondents, witnesses and attorneys for privacy purposes. This narrative enriches existing literature, which rarely reflects a judge's perspective on mental health. Professor LaFrance's conclusions are important—that a judge is, unfortunately, isolated from other agencies in the mental health system, that resources and personnel are inadequate, that the availability of community resources is important not only in serving the mentally ill but in defining them, and—finally—that existing definitions are overly broad.*

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Introduction

This article is based upon notes made a few years ago, when I sat as a circuit court judge *pro tempore* for the state of Oregon, conducting weekly mental commitment hearings for approximately a year. At that time, I had recently resigned a law school deanship and returned to teaching. The presiding judge,[1] perhaps sensing that I now had free time, suggested that I serve as a *pro tempore* circuit court judge, which I did for several years, conducting various civil dockets, with an occasional criminal case. He then suggested that I focus on mental commitments for a year, which proved to be an extraordinary experience. The notes that I made during that year have provided the basis for this article.[2]

Of necessity, this article is anecdotal[3] in ways not usually true of academic scholarship.[4] Mental commitment proceedings consist of "cases" conducted in a courtroom against a background of prior and subsequent agency processes. That interrelationship is important to understanding how the cases themselves are processed differently from most judicial work. Of course, the participants in the process and the respondents themselves, against whom the allegations of mental illness are brought, also relate to each other in ways quite different from the usual courtroom players. In addition, the statutes and formal procedures vary significantly from conventional due process models in assuming vaguely that the state is proceeding on behalf of someone, through behavioral science disciplines, while simultaneously trying to take the person's liberty away.[5] Understanding how all of this works (or fails to work) is best captured by summarizing cases in their richness and individuality. To that end, although names and dates and (frequently) places have been changed, there is here a genuine effort to reflect reality as it was played out in Room 220 of the Multnomah County Courthouse in Portland, Oregon, over the period of a year in the early 1990s.

Much legal scholarship is devoted to analyzing principles articulated in appellate court decisions. Most cases, indeed millions of them, never reach the appellate level. Thus the most important business of the judiciary is largely obscured from view and scrutiny. Nowhere is this more true than for what happens in court proceedings against the mentally ill, or the *allegedly* mentally ill. This article would be of value even if it simply recorded or reported the business of the court over the space of a calendar year.

It was clear to me when I made the notes underlying this article, and it is clear to me now, that conventional assumptions about the judicial process simply do not hold in mental commitment proceedings, at least as I viewed them in Oregon. Much of my time was spent in frustrating attempts to fit due process requisites onto the mental health process.[6] Equally important, my functioning as a judge required understanding—in ways not otherwise true elsewhere in the law—of how cases got into the courtroom and what would happen to them later, whether there was a commitment or commitment was refused. In short, I found that both the courtroom and the institution of the judge were tested and stretched in mental commitment proceedings. Along with this was a reconsideration of substance principles, as dependent upon the availability of resources and agency support in defining and determining the very concepts of mental illness and their application to individual citizens.

It is perhaps a mistake to state a conclusion at the outset, but it may be worthwhile in this instance as an inducement to the reader to continue. It seemed to me, in the end, that three propositions were clear. First, the tyranny of benign motives should be resisted whenever possible, in favor of formal principles of procedure and proof. Second, the withdrawing of resources from the agencies and institutions surrounding courts that deal with the mentally ill has profound implications[7] for the continued vitality and validity of those courts and their processes. Third, and finally, much of what

happened to the persons coming before me and much of what would happen was determined by agencies and institutions beyond the control and—most important—the knowledge of the court, leaving it and those appearing before it at risk of substantial error.[8] In this, the failure of counsel to play a conventional and competent role was a major source of risk.

This article does not attempt to elaborate or extrapolate beyond these conclusions, based as it is upon very limited experience. Still, I draw upon more than two decades of experience in practice and teaching, much of it devoted to courtroom concerns and constitutional decision making. Perhaps more directly relevant, I have taught and written about health care delivery and bioethics, within which a concern for human rights and mental commitment may appropriately be set. It is with that concern, first and foremost, that this article is undertaken and offered in the hope that it may enrich the knowledge and decision making of those for whom mental health is a continuing professional concern.[9]

I. Doing business as a court

After the first three weeks as a judge *pro tempore,* I wrote the following:

> There is, then, a species of public service that is especially involved in working in the nether regions of the judicial system. To be thought of, at the risk of seeming arrogant, as bringing light to dimly lit legions. In the first three weeks, it has been apparent to me that commitments have been wrongly sought against some people; that evidence and testimony has been poorly prepared; that the attorneys, particularly the district attorney, have invested little in screening cases; that the court-appointed experts spend no time whatsoever with the person to be committed prior to the hearing; that such rudimentary rules of evidence as swearing witnesses are often overlooked. And what has struck me also is that the role of the judge is, at best, viewed as an afterthought and even then perhaps might be disregarded.

A. Setting up the court

I was to hear civil commitments in Room 220 of the Multnomah County Circuit Court. I had been sitting as a judge in the circuit court for some four or five years, using various rooms throughout the building. The Multnomah courthouse is a large gray building some six or seven stories high, occupying a city block in downtown Portland, Oregon. It is made of stone, and the interior entryway is paved with stone with a large curving staircase going up from the center of the entryway to the floors above. There are elevators on either side of the staircase. The overall impression is one of handsome, conventional and dignified construction. Most of the courtrooms convey a similar impression. Some are modern, with blonde business-office styling, but most are high-ceilinged, dark paneled, spacious and imposing. Mental commitments are not heard in any of these.

Instead, Room 220 is set up as a conference room. It is large enough, approximately 30 feet by 40 feet, to accommodate an audience section and a long table. Around the table, typically, are seated the judge, the district attorney, the court reporter, the court clerk, a witness, the respondent, the public defender, and two expert psychologists or evaluators. It is clear that this is a room in which to do business, but it is not clear that the business is *judicial.* This might be a room where a planning and zoning commission could meet. It might be a room where a school committee would conduct its affairs. Similarly, a county board of commissioners might meet here. If the purpose is to ease the formality of the courtroom, Room 220 succeeds. However, it also conveys ambiguity and uncertainty as to who is in charge and what set of concepts governs.

The judge does not wear robes.

It has been my custom when sitting *pro tempore* to preview the coming day's work on the afternoon before. The files are assembled for me to analyze. The docket is typed and available. Frequently I will spend a couple of hours going through

the files and pleadings in order to familiarize myself with the status of the case, the issues crystallized, the probable proceeding on the next day, and, if possible, any potential resolution. And so on the Wednesday afternoon before I was to begin mental commitments, I went to the clerk's office in the probate section of the circuit court, asking for the files and docket.

I was told they were not available. When I asked, the response was they were only then being prepared. When I pressed further, I was told that nothing could be made available to me until 8:30 or 9:00 the next morning. I pointed out that the hearings were to take place at 9:30; the woman responded, acidly, that she knew that perfectly well. None of the other judges ever asked for anything in advance. I responded, trying to maintain a level voice, that I was a new kid on the block and so I wanted a head start. When this did not evoke sympathy, I then added that this had been my custom for a number of years and it did not seem to be a problem with any of the other clerks. Was it a problem for her?

The conversation then got significantly more tense. The woman added the idea that she was already badly overworked, since she had to make five copies of all the materials for the public defender, the district attorney and the court files. It occurred to me at that point that the materials *were* available. I pointed this out. The clerk was somewhat nonplussed, saying that might be the case; they simply were not available to *me*. This struck me as so incongruous as to be funny, and I started to smile. The clerk did not take this well. So I elaborated on what I thought was obvious: I was, after all, the judge. Why should materials be available to the people who worked for me, who appeared before me, but not to me myself? The clerk said that would require an additional copy. I said that was exactly my point.

Then we reached the final line: she needed permission. At that point, if not earlier, I realized I needed to take the matter

up a level and to stop demeaning myself in the process by allowing an assistant clerk to badger a judge. They do, in fact, have that power and propensity. The best way to respond is to retreat from the field of battle, pretending dignity, and to proceed at a higher level. After a ten-minute conference, the chief clerk and I went back to speak with the docket clerk, and an appropriate arrangement was made: I would get what the public defender and the assistant district attorney would get, no more. The material would be available late in the afternoon of the day before, with no special effort made to accommodate me. The docket clerk would not call me when it was ready. The messenger service would not deliver it. I would simply have to show up and pick up the material.

In life, one must take his victories where he can find them, and when. I thanked the people politely and left with the file papers.

The next day, at 9:30 a.m., when I prepared to call the first case, there was no clerk in Room 220. Nor was there a court reporter. Nor was there an assistant district attorney. There was an audience, and there was a public defender, and presumably there was at least one person in custody. But, in conventional terms, there was no way of proceeding. Without the usual functionaries, there could be no court. When an assistant district attorney finally appeared, I instructed her to arrange for the respondent, Tom Stevenson, to be brought into the courtroom from the holding area. I also instructed her to arrange for a court reporter. She said that the chief court reporter was tied up in a courtroom down the hall, where "call" was taking place. She was presumably recording the process by which cases for the next day were being assigned to a courtroom filled with 100 attorneys. I said that nevertheless we could get a court reporter through the presiding judge's office and instructed the district attorney to go there. When she started to reach for the telephone to call the presiding judge's chambers, I emphasized that I intended her to go physically and to bring back a court reporter physically.

A small edge once again was creeping into my voice. The district attorney left, she returned, and we had a court reporter. A court clerk materialized some time later. By then we had already begun the process of hearing the matter of Tom Stevenson.

These small tussles are of some significance. They were not institutional responses or maneuvers directed toward me as an individual. Rather, they simply reflected the low regard in which commitment processes are held by those who command the resources and the authority within the judicial system. Never before had that system failed to provide me with a court reporter or a clerk. Never before had we been unable to start on time. But then, never before had I been hearing civil commitments.

Another significant difference is reflected in the paperwork in the file in civil commitment cases. Essentially, there is none that lawyers or judges could recognize as conventional pleading or process. In either a criminal or a civil case, customarily the proceedings are started by a complaint: a formal document, signed by a government attorney, alleging violation of a statute by specific conduct on a particular date. Although such documents are customarily sketchy, they do set the outer bounds of a case and establish the elements that must be proved by the state. In the case of mental commitments, at least in Oregon, the only paperwork is a notice of mental illness signed by two people and served upon the county director of health and the judge of the circuit court. From this, the proceeding begins.

At least 24 hours before a hearing, an investigation report is filed. This report is prepared by a principal investigator, employed by the county. It is filled with hearsay, agency or institutional record notes, observations of the investigator, and impressions of friends, neighbors and family. At best, it could be characterized as evidence, although largely of dubious value. There is, then, very little in the file to alert

either the judge or, more important, the respondent (who is referred to as the allegedly mentally ill person), to what the state may and must prove or what the defense may insist upon.

From a legal perspective, this may perhaps be because the standards are so vague,[10] although this would be a reason for insisting upon more precise pleading. It may also be, from an agency perspective, that the professionals in the system know mental illness when they see it, a little like Justice Stewart's comment concerning pornography,[11] and so all that they deem necessary for the court is to submit their conclusions, not their descriptive narrative. Courts, however, are supposed to function as neutral, detached magistrates, finding their own facts and drawing their own conclusions.

Thus the file was not particularly helpful. When I heard the matter of Tom Stevenson, we started late, at approximately 9:45, because of the absence of a court reporter, a court clerk, and a district attorney. I had arranged for Mr. Stevenson to be brought into the hearing room despite the absence of such personnel. It could not have been lost upon him that he had been held in custody for a period of time, albeit brief, because of administrative failure to provide essential personnel. Nor could it have been lost upon him that this judge was not being treated with the allocation of resources essential to discharging the judge's role. Tom Stevenson was a young man, just three months shy of 32 years of age, thin, well dressed in a certain stylish sort of way, with a fair complexion, sandy hair, and a drawn, malnourished appearance. Two security guards sat on either side of him, dressed in green and apparently relaxed.

I had prepared a set of notes as to advice that I would give to each respondent at the beginning of the hearing. I learned from the assistant public defender that she had already fully advised Mr. Stevenson of his rights. At that point, the assistant district attorney began to speak. I took the matter away

from both of them and said that *I* would advise Mr. Stevenson as to the nature of the hearing and his rights.

The abbreviated advice that I gave, and continue to give, was that the hearing was for the purpose of inquiring as to whether Mr. Stevenson was mentally ill; if so, he might be committed to a state agency and hospital for up to six months;[12] there would be witnesses and testimony; the state would be required to go first, because it bears the burden of proof; he would have the right to hear the testimony, cross-examine witnesses, present witnesses on his own behalf, to testify or not as he chose, and to participate in all of this directly or through an attorney. I asked whether he understood all of this, and he indicated that he did. I asked the public defender whether she had had time to talk to Mr. Stevenson. She indicated that she had, and so I asked whether, in her judgment, he was able to proceed to participate in this matter and to exercise the rights I had indicated. She responded in the affirmative.

It appeared that this was all unusual and puzzling to the attorneys and the agency people. Yet it is essential to due process for the court—not counsel—to determine whether a person is competent to proceed, particularly in a case where the person's mental state may be at issue, as with an insanity defense in criminal proceedings or mental capacity in a commitment proceeding. Also, the advice as to rights is an empowering dialogue with the accused or the respondent. It informs him or her of the nature of the occasion and his or her role in it. No longer need the person deal with agency personnel at the discretion of the agency or subject to the authority of the agency. The person is now in a courtroom, and the presumptions are changed: the agency must prove its case, through the district attorney, and the respondent need prove nothing. In my experience as a public defender and as a judge, being placed in a position of parity with the government and being accorded important resources may be a unique experience in the lives of most citizens. It is an occa-

sion accompanied by historic traditions of dignity that are felt, at some level, by most people.[13]

Finally, giving a set of advice and inquiring as to a person's understanding with respect to that advice may produce a dialogue that in itself is helpful in determining the person's mental state and capacity. This was certainly true in the later case of Bruce Perry. With respect to Mr. Stevenson, the dialogue indicated that he was a young man of considerable intelligence and possessed of a quick and articulate mind and manner.

After advising Mr. Stevenson, I turned to the audience section of the hearing room. Approximately 20 chairs are located there. There were half a dozen people in those seats. I inquired as to whether any of them were interested in or involved in the matter of Tom Stevenson. Several hands went up, and I asked the people to identify themselves. One was the principal investigator, Steve Cole. One was Mr. Stevenson's mother, Carla Mann, and his stepfather, Kindal Mann. I asked whether the district attorney intended to call either of them as witnesses; she said she did not. I said to them that if, after the state's case had been put in, they had any comments they wished to offer, I would be happy to hear from them. At this, Mrs. Mann visibly relaxed, and we proceeded.

B. An average case: Tom Stevenson[14]

The public defender made his opening statement first, a rather odd proceeding, since in any other court setting the defense goes second. It is not that the defense is inferior or subordinate. Rather, it is that the state, the prosecution, or the plaintiff bears the burden of proof. There is much of symbolic importance in that sequencing. In any event, the statement essentially was that Mr. Stevenson should be discharged so that he might live with his parents; he lived presently with a roommate, or at least had until recently; he had been receiving treatment at a local hospital, Holiday Park; he was presently on vacation, and his appointment would recur on

Monday. The incident prompting the hearing, an attempted suicide, was simply one in which he had mixed two medications with disastrous consequences, but only through inadvertence.

The district attorney countered that Mr. Stevenson had a history of attempted suicide; the investigator would fill us in on the background; the mother was willing to take the respondent home; and the district attorney said that she did not have as witnesses the officer who took Mr. Stevenson into custody or any of the physicians. I asked where they were. The response, given with some vague amusement by the psychological expert sitting to my right, was that they never testify.[15] The public defender confirmed this.

During my year of hearing mental commitments, in no case did a hospital employee or a psychiatrist—the people best situated to describe the patients—ever testify. Mr. Cole had given a report to the clerk earlier that morning; copies were available to the district attorney, to the public defender and to me, at last. The district attorney offered the report into evidence. I asked whether she intended to call Mr. Cole to the stand. There was no witness stand as such, but there was a court reporter who could swear Mr. Cole, and there was an empty chair at the table where he could sit. I was told that was not customary. I said that my understanding of the rules of evidence was that it was not only customary but essential to put in evidence through a witness. Otherwise credibility could not be determined and cross-examination could not be undertaken. I restrained myself from observing that this was so sufficiently elementary that it should not have been necessary to make such observations. Mr. Cole was called and sworn.

He testified that he had talked with Mr. Stevenson, at which time he seemed credible. He had forgotten that he had previously interviewed Stevenson only a few days before. This admission in his testimony provoked a later comment by

one of the psychologists that such an oversight seemed quite remarkable. Mr. Stevenson had told Mr. Cole that there had been a big misunderstanding, that he had taken a Valium, then a Prozac, and then blanked out. Stevenson said he had no memory of having tried to kill himself. A police officer had said that he had taken 20 pills and regained consciousness in a room at Providence Hospital. All of this seemed credible and persuasive to Mr. Cole, but he changed his mind when he spoke with Mr. Stevenson's roommate and his mother, both of whom said that Stevenson had attempted suicide. Mr. Cole's report also quoted two different psychiatrists as saying they would not trust Mr. Stevenson and that he needed long-term commitment. Mr. Cole subsequently visited with Mr. Stevenson, who was still in custody, at which time he seemed lucid and pleasant, although Mr. Cole was struck by his "lack of responsibility." Stevenson became angry when he learned that he would not be released, although he did not lose control.

There was more. However, as is apparent, much of what the witness had to say was hearsay that would have been inadmissible in any other proceeding. I observed to the public defender that this was at least second- or third-level hearsay and that I would entertain any objection she might care to offer. My point, as most attorneys would understand, was that I had fully expected an objection to be made, and I did not understand why the public defender was not doing her job. It is always dangerous to attempt to discharge a lawyer's function when a case is unfolding. If the attorney has a winning case and keeps focused on the winning point, it is hardly necessary or wise to attempt other points. It may be that the public defender knew she was going to win and therefore did not choose to be distracted by side issues. On the other hand, since I had no previous experience with these attorneys or this kind of proceeding, it seemed to me equally plausible that she was not doing her job. She said that she understood my point and appreciated the invitation. The public defender stated, in what apparently is a commonplace concession in

these cases, that the report could be stipulated as a full exhibit except, of course, for the hearsay portions. The district attorney thanked her.

I admitted the exhibit as a full exhibit. I reserved mentally the point that if we were to exclude the hearsay portions, there would be very little left in the report of any significance on which the prosecution could carry its case. Moreover, since the witness himself, Mr. Cole, was in the courtroom, the entire report was hearsay, since it was his present recall and present testimony on which the prosecution was proceeding. What he had written or said on another occasion, at an earlier time, was simply inadmissible and itself complete hearsay. Thus what the physicians in the report were quoted as saying became double hearsay. On appeal, if there were a commitment, the appellate court could only conclude that there was no evidence whatsoever at this point.

Two other points should be noted about Mr. Cole's testimony. First, his report noted that two days after the friend and the mother made their accusation of attempted suicide, they both recanted. The friend told the investigator that he had said Stevenson took 20 pills only as a way of ensuring that Stevenson would be taken into custody, because they had been arguing and Stevenson had been depressed for a long time and seemed out of control. The mother said that the friend had prevailed upon her to recite a similar story so as to get Tom some help. They both changed their stories, as reflected in the report Mr. Cole submitted.

Second, at the conclusion of his testimony, the psychological examiner asked Mr. Cole for his diagnosis as to precisely what form of mental disorder or defect Mr. Stevenson had. He had asked Mr. Cole a series of questions without an invitation from me, somewhat to my surprise. At this point, I said that I thought Cole's credentials to give an opinion had not been established, and that I was looking to the psychological advisor, not to Cole, for such an evaluation. The advisor,

Dr. Miles, evidencing that he was in control and familiar with the way these matters should go, regardless of what I might think, said that although Mr. Cole's opinion might not be helpful to me, it was helpful to him, and he would like to have it. I sat back, intrigued by this, and let Mr. Cole respond that Mr. Stevenson had a "borderline personality disorder." It occurred to me at that point that I had a borderline procedural disorder in the courtroom.

The district attorney then offered into evidence two pieces of paper that she said she had obtained either directly or indirectly from the mother and the respondent. One was a letter from the friend who had caused Mr. Stevenson to be taken into custody, and the other was from Mr. Stevenson's sister, who essentially was writing to say that she loved her brother. I responded to the offer by saying that, again, these documents were hearsay and could be admitted only if authenticated, and perhaps not even then. The public defender said she had no objection to the documents being admitted. At this point the mother, Mrs. Mann, stood up in the back of the courtroom and asked if she could be heard. Since all the other rules were being broken or ignored, it seemed to me only appropriate that she have her turn, and I invited her to speak.

Mrs. Mann said essentially that in all of the process of taking her son into custody, holding him in a local hospital, and dealing with the agencies, including Mr. Cole, nobody had been willing to listen to the family, and I was continuing this pattern. She thought the court should listen to the family and read the pieces of paper.

I was impressed by her comments and told her that she would certainly have the chance to testify within a few minutes. As to the pieces of paper, if their writers had things to say to the court, if they truly cared about her son, they should have made it their business to be in court as she had. Finally, I said that my insisting upon testimony by the investigator and

proper procedure with respect to the letters was probably the best protection that could be accorded to her son, since without evidence properly admitted, he could not be committed. I was not setting up roadblocks to his release; I was setting up roadblocks to his commitment. With that, Mrs. Mann sat down, somewhat more relaxed than she had been when she stood up.

It is unusual to seek testimony, willy-nilly, from members of an audience. In a mental commitment, not only is there a right to be heard, but there may be a need to vent frustrations and have a sense of participation.[16] If the hope is that the family will be a resource in caring for or treating a mentally disturbed person, then the family or the neighbors must be given a role in the process. Equally important, from a somewhat more legalistic perspective, the opportunity to testify, either for or against, creates belief that the system is effective and ensures, in some small measure, that there is truth in that view.[17] It is therefore important that all voices be heard. To refuse to hear them only engenders further frustration, and perhaps violence, while reducing the willingness of a family or a community to assist in returning a person to them for care and support.

With all of this, it is still necessary that any participation be according to the rules of evidence, so Mrs. Mann was sworn as a witness and testified. She said she was prepared to bring her son home to live with her and her husband, his stepfather. Her son had been living in a bad situation with a problematical companion. He had been working at the same job for 11 years, a fact that was not reflected in the investigation report or the testimony of the investigator, Mr. Cole. Her son did need psychological assistance, and she would help him to get it. She had seen him in the hospital, and it was clear to her that he would not benefit further from continued commitment. The suicide attempt had simply been an instance of mixing medications. She was able to authenticate the daughter's statement and also that of the friend. I admitted these,

since there was no objection from the public defender, although they remained hearsay.

Obviously, with such testimony many of the usual constraints of the rules of evidence simply cannot operate. For example, Mrs. Mann was giving opinions as to her son's mental condition. She was giving opinions as to whether continued care would be helpful. She was opining as well about the nature of care and of institutions available in the State of Oregon. No basis had been provided as a foundation for these opinions. Yet in the course of rendering such opinions, Mrs. Mann was evidencing much that was important: she had a strong personality, she had a home that was available to her son, she cared for him and would help him to get care, and she loved him.

Mr. Stevenson then testified. Essentially, he said that he had a drug problem involving marijuana. He also said that he had a problem with depression, which had caused him to think about suicide and talk about it. He had expressed suicidal feelings that were of an idealized order, but he had never planned a suicide and had no goal to commit suicide. His medications were for migraines, which sometimes crippled him for days, and for tension and depression. He usually took them separately. He had never mixed them before. He had no recall whatsoever of having attacked his roommate. Although they had been arguing of late, it seemed to him unlikely that he would have attacked his roommate.

Throughout his testimony, Mr. Stevenson spoke articulately and with a slight edge of indignation that he had been restraining for the past several days. His choice of words was precise, often reflecting a certain pseudo-psychological jargon, as might be expected of a person who had been in counseling on an extensive basis. He had no reason to believe that either of the two psychiatrists who had declared him not to be trusted and not fit to be at liberty had actually made such

statements. Indeed, he had recently spoken with both of them, and neither had indicated such sentiments.

I then asked the psychological examiners to ask Mr. Stevenson some questions. When they were done, I asked them whether they had previously spoken with Mr. Stevenson. They both had said they had not and that it was not customary to do so; instead, they based their evaluation on what took place in the hearing room. The statute provides that the court is to have available to it psychological examiners.[18] One would expect that like experts in other cases and other courtrooms, they would do their preparation before coming to court and have a recommendation based upon it.[19] It was remarkable, then, that the examiners were conducting their examination as we proceeded and were filling out their forms as they went along.

The method of questioning of the two examiners was an interesting contrast: one, the older evaluator, asked questions in a legalistic, almost cross-examining mode. The other, Clark Annson, asked questions of a more rehabilitative or therapeutic mode. Both established, which was already quite obvious, that Mr. Stevenson was well oriented and in control of himself and had a place to go and live and a job to do. When they were finished, I picked up on this last point. No one had developed precisely what Mr. Stevenson's job was. It turned out that he worked for a sheltered workshop, where he did skills training. The training apparently was on a basic level, as he was working with developmentally disabled individuals, and included such elementary assignments as feeding or dressing oneself. Mr. Stevenson had been doing this for 11 years.

Both of the psychological examiners appeared to recommend that Mr. Stevenson be discharged. The conclusion of one was that he suffered from a mental defect but was not a danger to himself, could provide for his own care, and was not

chronically mentally ill. The conclusion of the other was simply that Mr. Stevenson did not suffer from a mental defect. Both counsels asked me to accept the recommendations of the evaluators. I skimmed the single-page recommendations, executed by the examiners as the proceeding progressed, and told Mr. Stevenson what the recommendations were and that I would find no basis for commitment. At that point in the proceeding, it might have been appropriate simply to discharge Mr. Stevenson and let the matter go. In a formalistic sense, there was nothing further to do.

However, the hearing involved an intrusion on a young man's liberty, the fracturing of a personal relationship, trauma to a family, and, in my judgment, the miscarriage of agency processes. I therefore concluded the hearing by telling Mr. Stevenson that it seemed to me he was a young man of great promise. I commented further that although he had said his life seemed to be drifting and that he despaired of it often, there appeared to be much promise to his life and value and worth in his family. A sister who would write a strong letter; a mother who would take a son back into her home; a stepfather who would support both of them in this—these are rare and valuable assets. It also seemed to me that a young man who had held a job for 11 years and was engaged in valuable public service should be commended and supported, not committed. The only advice I could give him was to be more careful in his selection of friends and in his expression of suicidal thoughts or tendencies. He had the court's best wishes, as did his family.

With that, we concluded.

It has been my custom for years, when sitting as a judge *pro tempore*, to ask the impressions of the other courtroom personnel concerning my mode of proceeding. I have fairly clear ideas as to what a judicial proceeding requires. Some of these are philosophical; some of these are born of experience; some of them are born of reading and, for that matter, of statutory

or case law requirements. Still, there is a large latitude for personal choice of style, and I am always curious as to how far I deviate from the usual routine of the judges whom I am replacing. Therefore I asked the assistant district attorney for any impressions that she would care to share. Her response was revealing. She thought the case had gone on too long. In fact, we had taken nearly an hour and a half. Her impression was that such matters usually take much less time. What was most significant, however, was that she said she usually did not handle mental commitments; indeed, she had just received the file some 15 or 20 minutes before the hearing was to take place. For this reason, she had been unprepared and had not offered much of a case for the state. Also, she was not really quite certain what role the state should play in these proceedings.

Over the succeeding weeks, this pattern recurred.[20] Junior district attorneys appeared for the State. Typically, they had not looked at the file beforehand, or, if they had done so, they had had only a few minutes. Such limited preparation is of little value. The State and the respondents are badly served under such circumstances. There can be little opportunity to screen out cases; less opportunity to establish expertise in presenting cases; and even less occasion for establishing continuing relationships, guidelines or expectations for the agencies that bring people into court. The failing of the district attorney's office was a major deficiency in the mental commitment process.

The public defender then commented that in her judgment an hour and a half on this matter was appropriate. This, in her view, was a difficult case. A person who appears to be suicidal is at significant risk, and careful inquiry is necessary. With that, I said I felt better having taken as much time as we did, but that really the inquiry had not been as careful as it should have been, since the people who knew Mr. Stevenson best were the physicians who had seen him while he was in custody or who had treated him prior to custody, and not one

of them had appeared. Dr. Miles said that was customary, and that I was one of the few judges, if not the only judge, to question why that would be so. I said I intended to continue raising the question, and if I had thought commitment might be appropriate, I might well have continued the case to subpoena the doctors. The district attorney and the public defender found that an intriguing notion.

At this point, Mr. Stevenson and his mother approached me. They expressed their appreciation for the outcome, but, more important, the mother said she wanted to express her appreciation for the way in which the hearing had been conducted. Over the preceding days she had tried in vain to talk with people at the hospital or at the agency. The principal investigator, she said, had been rude to the point of being insulting. The hearing had been their first opportunity to say anything in a meaningful way. They thanked me again and left.

The Stevenson case is significant precisely because it was average. The conduct of the respondent, the witnesses, the agencies, the institutions—all were quite typical. Therein lies its noteworthiness.

First, the process that brought Mr. Stevenson into the courtroom is deficient. He was taken and held on the allegations of a single person and was kept in custody well beyond the point when that person had changed his story. The hospital where Mr. Stevenson was held generated records that came into the courtroom; but there were no witnesses from the hospital. The agency that prepared the report included hearsay and double hearsay, yet it did not undertake fully to include or to capitalize upon the mother and the family resources. Indeed, the principal investigator did such a superficial job that he did not even recall having spoken with Mr. Stevenson a few days or weeks earlier. Subsequent cases confirm that these investigators, while they may have social work or counseling or psychology training, even at the master's degree level, are frequently poorly trained and overworked, with little super-

tions like that to which Mr. Stevenson would have gone.[27] As a result, the capacity of such institutions to provide the care that the statute assumes will be there is seriously in doubt.[28] Add to this, as impacting the capacity of state agencies and resources, the experience in many states, including Oregon, produced by tax reduction initiatives.[29] In Oregon, the result has been disastrous for the very state institutions that serve the most needy, underprivileged and deprived.[30] Most categories include the mentally ill.

C. Defining mental illness

The Stevenson case illustrates a need to look hard at the statute governing mental commitments. In mental commitment proceedings, there is a collision between two very different ways of looking at law. One may be characterized as the due process model, which treats hearings as adversarial proceedings between equals.[31] The outcome is truth, and the party bearing the burden of going forward may lose simply by failing to bear the burden. The other view is the view that comes from decades or centuries of public health legislation. It presumes an obligation to care for those who cannot provide for themselves.[32] In that view, the state has an obligation beyond procedural truth, to ensure care, treatment and rehabilitation. Since these can only be considered good, the need for procedural niceties and burdens of proof may be masked or ignored. If errors of inclusion are made, they will in any event be thought helpful to the person who is in need of treatment.

The Oregon statute in many respects reflects this orientation[33] and is typical in doing so.[34] It may be useful to examine it closely as a vehicle for understanding the criteria, the processes, the constitutional background, and the play of forces in commitment hearings. To begin with, the statute requires at least a two-step process before commitment can take place.[35] The court must find that the respondent suffers from a mental defect,[36] which is nowhere defined. Then the court must further find that the defect has certain consequences:

vision. Thus the process that brings people into court is most intrusive and yet has little selectivity built into it.

Second, the process in the courtroom was quite remarkable. Judicial hearings, regardless of the issue, have certain requisites. There must be witnesses sworn and testifying.[21] The party with the burden of proof must be prepared to go forward and to take the initiative.[22] The expert witnesses must prepare beforehand and be qualified, by testifying about their expertise, to render an opinion.[23] The processes within the courtroom itself must be left to the judge. Stipulations are usually designed to ease the introduction of evidence, not to create substitutes for it. The proceeding against Mr. Stevenson, at least as it unfolded, severely compromised all of these requirements.

Third, the place where Mr. Stevenson would have gone, if committed, is *terra incognita.* The statutory provision is simply that the judge commits the defendant to the Department of Mental Health and Retardation.[24] Where Mr. Stevenson would have gone, what would have happened to him there, or how long he would be controlled, subject to what continuing control: all of this is left entirely to administrative discretion.[25] When I asked in the hearing, I was told that this was not usually a matter for a judicial inquiry. Nevertheless, the availability of care, the quality of institutionalization, and the continuity of support and assistance are all essential to the question of whether commitment should be undertaken. It is a matter of due process, of a most elementary nature, that before society may take away a person's liberty in order to treat that person, it must demonstrate that treatment is available and will be provided.[26] This is a *quid pro quo* mission of due process. No evidence whatsoever was offered in the courtroom that the state would discharge its obligation if Mr. Stevenson were to be committed.

Over the past two decades, there has been a national movement to reduce the size, populations and resources of institu-

risk to self, risk to others, or inability to care for self.[37] If it does, a commitment to the Mental Health and Developmental Disabilities Services Division is undertaken.[38] The court's role is then at an end. This curious skeletal, truncated, crabbed role deserves closer analysis.

The Oregon statute defines a "mentally ill person" as one who "because of a mental disorder" is "dangerous to self or others," is "unable to provide for basic personal needs and is not receiving care as is necessary for health or safety" or, finally, is a person who is "chronically mentally ill," has twice been placed in a hospital within the preceding three years, is "exhibiting symptoms or behavior substantially similar to those that preceded and led to one or more of the hospitalizations," *and* "unless treated, will continue, to a reasonable medical probability, to physically or mentally deteriorate."[39] The deterioration must be such that the person will become either dangerous to self or others or unable to provide for basic personal needs.[40] "Chronically mentally ill" is further defined, in a separate section of the statute, to mean a person who is "suffering from chronic schizophrenia, a chronic major affective disorder, a chronic paranoid disorder or another chronic psychotic mental disorder other than those caused by substance abuse."[41]

People fitting these various categories—dangerous, unable to provide, chronically ill—may be committed if the court is convinced "upon clear and convincing evidence."[42] Despite such evidence, the court "shall" order the release of the individual if he or she is "willing and able to participate in treatment on a voluntary basis."[43] The court may also order conditional release if "requested by the legal guardian, relative or friend" and that person "requests to be allowed to care for the mentally ill person during the period of commitment."[44] Thus a conditional release is in fact a commitment. Other than a voluntary release or a conditional release, if the court finds the person is mentally ill, it *may* order commit-

ment to the mental health division or treatment for a period of time that the court shall establish, not to exceed 180 days.[45]

There are a number of significant omissions in the statute.[46] There is no preamble or set of articulated principles or policies. There is no precise set of criteria to guide the courts. There is no provision for recognizable proceedings, in which the citizen would be a respondent and the state would proceed by petition or complaint. It is as though in some fashion the citizen is to be deposited in a room and labels are to be hung in the room and on the person. There is also an unreality in the consequence to the labeling: the statute makes no provision for where a person should go or what may be done to the person. A commitment, simply, is to the "Division," not even to a department or commission.[47] All of this is reposed within the circuit court,[48] where it is a truly anomalous proceeding, since circuit courts, like others, are accustomed to responding to complaints that initiate proceedings against citizens who are named as defendants or respondents. Curiously, there is no name for the allegedly mentally ill person under the Oregon statute; they are referred to as AMIPs.

Following a commitment, the mental health division, "[i]n its discretion and for reasons which are satisfactory to the division, . . . may direct any court-committed person to the facility best able to treat the person. The authority of the division on such matters shall be final."[49] The statute then goes on to provide that "[a]t any time, for good cause and in the best interest of the mentally ill person, the division may transfer a committed person from one facility to another."[50] The committed person, then, is submitted to a fully discretionary and "final" authority of the mental health division.

Any two persons or a county health officer or a magistrate can initiate a commitment by preparing a "notice."[51] The proceeding is not—and it must be assumed that this is a deliberate choice—initiated by any pleading or paper otherwise conventionally known to the law and its processes. Instead,

the "notice" initiates commitment procedures by being given to the community mental health program director saying that some person is a "mentally ill person and is in need of treatment, care or custody."[52] The director then notifies a judge and the state division and initiates an investigation to determine whether there is probable cause.[53] Upon completion, a recommendation "shall be promptly submitted to the court."[54] Throughout this process, the person under investigation receives no notice or opportunity to participate.

Upon receipt of the notice, the judge may cause the allegedly mentally ill person to be taken into custody pending the investigation.[55] Following the investigation, if the court concludes that there is probable cause, it arranges for the person to be brought before it for a hearing.[56] The statute describes at great length the timing of the investigation and the contents of the resulting report,[57] obviously contemplating that the report will play an important role in the hearing, quite probably in lieu of live testimony. The investigator has full access—without the person's permission or knowledge—to medical records,[58] which are declared "not privileged" under relevant Oregon statutes.[59] A copy of the report must be provided at least 24 hours prior to a hearing to the AMIP and his or her attorney, as well as to counsel "assisting the court, to the examiners and to the court for use in questioning witnesses."[60] At the hearing, the court may have the assistance of examiners.[61] The statute provides that the court will have appointed them "sufficiently long before the hearing so that they may begin their preparation for the hearing."[62]

A "citation" must be served on the respondent, stating the reasons why the person is believed to be mentally ill.[63] The citation must provide an opportunity for consultation with counsel.[64] Any hearing will be five judicial days from the day the citation is issued.[65] Both sides shall have a right to cross-examine all witnesses, the person conducting the investigation, and the examining physicians.[66] As to the last, the statute specifically provides that the usual provisions governing

hearings (OR. REV. STAT. 40.230 and 40.235) will not apply to the hearing[67] and that the court may consider as evidence statements attributed by the maker of medical records or the investigation report to witnesses concerning their own observations in the absence of objection.[68]

As to the investigation report itself, the statute provides that it "shall be introduced in evidence." This does not "require the consent of the allegedly mentally ill person."[69] Upon objection by any party, the court will exclude any part of the report that may be excluded under the Oregon Evidence Code (on grounds *other* than those set forth in ORS 40.230 or 40.235).[70] The upshot is that the case against the responding citizen may consist largely of hearsay or double hearsay, unconfirmed and unsubstantiated, and presented in a report that may, by its selectivity or lack of balance, skew the case toward commitment. The statute does at least require the investigator to be present and to be cross-examined unless waived by the respondent,[71] but it does not require that the investigator be sworn when the report is introduced.

The status of the report is thus unique in the law. For example, presentence reports in criminal proceedings are not treated as evidence, nor is it anticipated that they will supplant the place and role of live witnesses.[72] In probate proceedings, in criminal trials, and in civil cases, the Rules of Evidence very jealously guard the requirement that testimony be by live witnesses, attesting only to what they themselves know or have observed. The whole thrust of the mental commitment statute turns the conventional wisdom topsy-turvy. It would seem that live witnesses are intended to be the exception.

The prehearing investigation report is clearly intended to play a major role. Equally important, under the statute, is the role to be played by the court's examiners. These are either physicians who are competent to practice psychiatry or people who are certified "as a mental health examiner" by the mental

health division.[73] The statute requires that the examiners initiate the examination process "prior to the hearing,"[74] but it quickly adds that "any failure to comply with this paragraph shall not, in itself, constitute sufficient grounds to challenge the examination conducted by the examiner."[75] The examiners make their reports in writing to the court.[76]

While the reports are to be "under oath,"[77] it is clear that they will probably not be verbal and therefore will not be heard by the respondent who faces commitment. The examiners are required to determine whether the person is mentally ill,[78] and the report is to include a recommendation as to the type of treatment facility "best calculated to help the person recover from mental illness."[79] Each report must also advise whether the person "would cooperate with and benefit from a program of voluntary treatment."[80] The close connection between the examiners and the mental health division is demonstrated by the provision that reports shall contain "the information required by the Mental Health [Division]."[81] The examiners must also be licensed by the division.[82]

If it appears upon clear and convincing evidence that the person is mentally ill, the court will order release of the person voluntarily participating in treatment.[83] Otherwise, the court may order conditional release,[84] essentially releasing the person into the custody of a relative or friend. The most frequent result, and the one having the most significance, is commitment to the mental health division for treatment.[85] The court is given no authority to impose conditions upon the treatment other than establishing a period of time.[86]

By comparison, in a criminal or a juvenile case, a sentencing court has a number of alternatives available to it for sentencing purposes, including limiting terms of custody and selecting the facility to which a person is sent.[87] Under the mental commitment statute, the person is simply entrusted to the mental health division, which has absolute authority to proceed as it wishes.[88] This being true, no other evidence is

required to be presented before the judge as to whether the mental health division even has an appropriate program or place. When choosing between conditional release, voluntary treatment and commitment, the court in essence is playing a game of "blind man's bluff." The court apparently may not even provide for the committed person to be returned after a period of time for further consideration or review.

The importance of a critical review of the Oregon statute can be illustrated by the case of Trak Seljohn. Mr. Seljohn appeared in the hearing room quite intact and alert. He was 40 years old, slightly less than average height, physically fit, and only a bit hostile. Under somewhat probing questions by one of the psychological examiners, Seljohn became testy, but later he apologized. When asked whether it wasn't true that he had had a lot of admissions to the mental health hospital, he answered *No*. When it was pointed out that in fact he had been admitted and released over 17 times, he responded that he would not consider that "a lot." Other than this prior history, however, there was very little evidence on which to commit Seljohn again. The investigator was present, and his report was offered. Essentially, it showed that Mr. Seljohn had been staying at a place called "River Run," where he had threatened the manager and had accused the cook of putting cyanide in his coffee. Neither "victim" was present, and the investigator had not spoken with them personally; the allegations, therefore, were the grossest hearsay and remained unsubstantiated.

I afforded Mr. Seljohn the opportunity to say whatever he liked, and I reviewed with him his rights and the purposes of the hearing. During these exchanges and the exchanges with the psychological examiners, Seljohn revealed a good deal of his thinking, including: a belief that he was working for either the FBI or the CIA; that not only he but also Rocky Marciano had found cyanide in the coffee; that he had a wife who could have been contacted, since they had married only the preceding Sunday, but this was for the second time, hav-

ing previously been married at ages 13 and 15, although they never lived together; and that he had served in Vietnam from 1974 to 1978, where he had flown planes and sailed submarines and served extensively. The investigator assured us that none of these assertions were true.

The problem was this. Seljohn was not a danger to himself, nor had it been shown that he was a danger to others. It also had not been shown that he was unable to support himself or, if he worked, that other means of support were unavailable. This left the third category in the statute, the possibility that Seljohn might be considered "chronically mentally ill." He seemed at least superficially to meet the criteria. He had been twice placed in a hospital within the previous three years; he was exhibiting symptoms that doubtless had persisted for years and therefore might be "substantially similar to those that preceded and led to one or more of the prior hospitalizations"; and it seemed possible that unless he were treated, he might continue to deteriorate "physically or mentally" and thereby become a person who was dangerous or unable to provide for himself.

I therefore raised with the district attorney, the public defender, and the psychological examiners the question of whether we should consider the possibility that Mr. Seljohn was "chronically mentally ill" as grounds for commitment. The response was quite surprising. The examiners said that no judge had ever used that provision, as far as they were aware. They added that the provision was referred to in the profession as the "expanded criteria," having been added several years previously, some 10 years after the basic statute.[89] The district attorney, who was brand new to the office and utterly unprepared, had little to offer. The public defender, who had served in the mental commitment division of the court for a year and a half, commented that no one had used the chronically mentally ill category, as far as she knew. Moreover, she quite correctly pointed out that the evidence did not support a finding that today's symptoms had also

preceded earlier commitments, nor had anyone given an opinion "to a reasonable medical probability," as required by the statute,[90] that Seljohn would continue to deteriorate. That observation was correct, and so the "chronically mentally ill" grounds of commitment were unavailable.

However, considering that provision raised a number of questions that are apparent on the face of this statute. First, how would it be possible for any expert to say that Seljohn was exhibiting symptoms similar to those preceding the prior hospitalizations unless the person had been involved in them as a physician, case worker or psychological examiner? Second, how could such a person give an opinion close to a "reasonable medical probability" that Seljohn would continue to deteriorate, becoming dangerous to self or others or unable to provide for basic personal needs? There was little to suggest that he was a danger or was becoming a danger. As to his inability to provide for basic personal needs, any professional so testifying apparently would have to concede that on his earlier releases Seljohn provided for basic personal needs in some fashion. Therefore they would also, of necessity, have to concede that the means for doing so were still in place and the grounds for commitment could not be sustained.

What is perhaps most problematical, however, is that the evidence suggested that Seljohn was being "churned" by the process. He was being considered for commitment only because he had previously had contacts with a mental hospital and had been through the system. Thus, in a very ominous way, the system perpetuates itself and its patients' status. The other grounds of commitment are statuses relating to the individual; the third ground, chronically mentally ill, is specifically a status relating to the individual's relationship to the bureaucracy. As such, it is a product as much of the deficiencies of the bureaucracy and system as it is a product of the individual's mental or emotional shortcomings.

This summary review of the Oregon statute legitimately raises several concerns. First, the emphasis in the substantive law is not on substantively defining the *meaning* of illness and the grounds of commitment, but on establishing *process* for committing people who are ill. Second, *process is* emphasized at the expense of *procedure,* which requires pleadings, witnesses and evidence. Third, the court in this scheme is more an afterthought or way station than an adjudicative body serving a central function important to the public and the citizen alike.

Unquestionably, the family of values and professionals is that of the social service–mental health world. A judge is a stranger there, in a strange land indeed. Apart from the obvious observation that the process provided for commitments creates a high likelihood of error, it also demeans the institutions of justice, isolates them from the other players in the system, and provides no chance for control. By contrast, in the criminal system judges routinely rule on police conduct or misconduct, often in the presence of the police themselves.

The case of Trak Seljohn well illustrates this disparity, since he was a prime candidate for the "expanded criteria" portion of the statute. In his case, as in many others, a judge has no way to scrutinize past churning, present process, or future placement. Rarely has the Constitution allowed so much to be done to so many with so few safeguards.

II. Who are the mentally ill?

A. Ordinary people

This section is an attempt to describe "ordinary people." In a case where somebody is suicidal and the evidence is clear and convincing, there are no hard questions. Commitment is appropriate. In other cases, where it appears that the person is capable of functioning in the greater society but is at war with particular case workers or case agencies dealing with him or her, there are similarly no hard questions. In a range

of other cases—for example, where someone has stabilized quickly on medication—hard questions as to commitment simply are not present. Nevertheless, difficulties present themselves in a vast range of cases.

It is hard to know how to deal with the elderly in the mental health system. There are also cases where the person's dysfunction is a product of rage against the system, and such people present, as a class, difficult questions of the appropriate response. The same may also be true of socially dysfunctional behavior, such as alcoholism or drug addiction, which may manifest itself in terms usually appropriate for mental commitment. Thus there are many classes of people who may be appropriate for treatment in the mental health system but who pose problems under existing statutory definitions or under conventional conceptions of what the mental health system is about.

Other portions of this article describe some of the difficulties with defining mental illness and determining who should be committed. Some of the objections are that the definition is political; some, that it is institutional; some, that the definition represents a melding of different disciplines that essentially do not speak to each other. It is also true that quite apart from the definitional difficulties in the statute, commitment requires an appraisal of the facilities and services available without commitment, as well as the facilities and services that would be available only through commitment. Thus a commitment decision is based upon the qualities and deficiencies in the person involved, but is also equally based upon the qualities and deficiencies of society's allocation of resources. In any one case, not all of these considerations may come to bear, but in many cases they do.

The people to be described in this portion of this article are people who may be quite appropriate for consideration under the usual statutory definitions, allowing for commitment if the person has a mental defect and is a danger to self or to

others or is unable to provide for basic needs. Yet the outcome is far from clear. The concern must be at all times to assess the existence of and effect or extent of the defect and whether the defect means the person is a danger to self or others or is unable to provide for basic needs. The answers to these questions turn in part on whether there are resources (family, agency, etc.) to support the respondent at home, without institutionalization. These are truly ordinary people, but they pose hard questions.

Roland Tell appeared in Room 220 pursuant to a notification of mental illness on a physician's "hold," which Andy Marksson had signed. The notation concisely stated that "he is clearly manic and psychotic. He is threatening to kill people that want to give him medications. He has been destructive today." It appeared in the paragraph of the form where the "undersigned" states his reasons for his belief that the "person is dangerous to him/herself or some other person and is in need of emergency care and treatment." Attached to the notification of mental illness was a two-page form, also entitled "Notice of Mental Illness," this one signed by Cal Thomas, M.D. Dr. Thomas's notation as to why he believed the above-named was dangerous stated:

> Irrational behavior with self-harm actions—breaking glasses, cutting toes. Violent outbursts with threatened harm to medical personnel, security police. Report by brother of violent and destructive outbursts at home and damage to [indecipherable].

By all appearances, Mr. Tell was a man who was angry at being locked up in a hospital. The report of precommitment investigation, done by Felicia Rex, confirmed this assessment somewhat. Her interview with Tell reported that "the client" felt his brother had tricked him into going to a hospital on the pretext of seeing a counselor, and that he became quite upset when he "figured out that he was tricked." There was then a confrontation with the police. She said Mr. Tell did not believe he was "crazy" and that he should not be in a hospital. He stated that he was an inventor, and it was because he

was so excited about his invention that he had been missing some sleep. The invention was a piece of plastic about the size of a coin that "you put in front of your eye and look at anything and you can make it 3-D." He stated that he had a 50-page patent on this particular invention. The report went on to say:

> In confronting this client with the fact that he has been somewhat hypersexual on the ward, he stated that he used to be a counselor and that he has started numerous groups in various counseling agencies. He states that he knows how to get through to people. In asking how this was in answer to my question, he stated that it wasn't, he just wanted me to know that.

The report then went on to say that Mr. Tell's brother reported that Mr. Tell had been "sent out to Oregon by his ex-wife because of his increasing hyperactivity." Such episodes had happened in the past, and Mr. Tell would "settle down." Mr. Tell had had one prior hospitalization in Oregon and four or five in Virginia.

The conclusions in the report were unusual. Ms. Rex noted that Mr. Tell was "neat and clean, dressed in street clothes." His speech was "clear and coherent." He was angry during the interview and "he did admit to ideas of reference," while denying any "auditory or visual hallucinations." She found his ideas concerning inventions to be "pretty much of a grandiose, delusional system," although his statement that he had been accepted into medical school might be "based on reality." He was "oriented X4," and his recent and remote memory "appeared to be unimpaired," although she concluded that his "judgment and insight are nil." She also concluded that "this client does not recognize that he has a mental illness, nor is he willing to take any medications."

This analysis contrasted significantly with the usual observations and conclusions. The picture presented was that of a man who was angry at being held in a hospital, who was hyperactive and perhaps out of touch with his own limited

prospects and potential, but who apparently was functioning well. Nothing appeared as to Mr. Tell's work record. There was nothing to suggest that he could not return to his home in Virginia or continue living with his brother. Everything was consistent with a man who takes care of himself and represents no threat to himself or to others. Yet the report concluded that

> this client is currently unable to meet his basic needs due to his poor judgment and his current state. He has been hypomanic for quite some time and has become quite grandiose over the past several weeks . . . . He is unwilling to receive treatment, which in itself is not a reason for a hearing, although I feel that currently it is poor judgment on his part. He does have a history of time where he does not need medication where he functions quite well. Currently, I do not believe this is true and my fear of letting him go is that he will decompensate more and become dangerous both to himself and others in the community.

With that, Ms. Rex checked the "Yes" boxes, meaning "Mr. Tell has a mental disorder and is dangerous to self and to others, and is unable to provide for his or her basic personal needs." Nothing in her report would support such a conclusion—certainly not by clear and convincing evidence.

However, there was something about Roland Tell that bothered his brother and Ms. Rex so much that, absent objective criteria and evidence, they nevertheless were moved to seek to have Mr. Tell treated as mentally ill.

Mr. Tell described the quality that they found so disturbing as his "power." In the hearing room, he sat at the end of the table, a 52-year-old man over six feet tall, powerfully built, handsome in appearance and attractively dressed, possessed of an animal energy and barely contained strength that radiated from him in all directions. He was quick, articulate, and engaging. He spoke to those around him in unconventional yet appropriate ways. He spoke intelligently, but occasionally with crude language to make a point. On two occasions he pounded the table with sufficient force to make it resonate, at

times that were deserving of emphasis but with a strength that was intimidating. During the psychologists' examination, he turned to the nearest psychologist when she was asking him about his hypersexuality; he simply said to her that he had a "power," and then asked her whether she didn't "feel it"? She answered that she did. Others in the hearing room would have answered affirmatively as well.

There was a quick and not entirely inappropriate self-assurance about Mr. Tell. When it appeared that there were no witnesses against him, I commented to the district attorney that simply offering the precommitment investigation report would not be sufficient, and that if he did not present witnesses, "Mr. Tell will simply walk out that door." At this, Mr. Tell immediately stood up and took a step toward the door. His eyes were on me, and he was smiling a little. I commented, "Not yet, Mr. Tell. Please have a seat." Mr. Tell sat immediately. There were a quickness, an energy and a control about him that rearranged the power balance in the room in ways that were substantial and real.

Ultimately the investigator appeared in the hearing room, in response to a telephone call, along with Mr. Tell's brother and nephew. The investigator testified in support of the conclusions reflected in her report. She referred to Mr. Tell's having rather confused plans as to where he would go upon discharge. She also referred to his having disrupted a wrestling match at his brother's son's school, which drew an objection on hearsay grounds. She also described Mr. Tell's "hypomania" as being manic hyperactivity, but of a lesser order than true mania, hence the prefix "hypo." As to hypersexuality, Ms. Rex essentially described a man who was "coming on to" nurses and staff and, on report from his brother, others as well.

When the hearing started, I had given Mr. Tell the usual advice as to rights, including his right to be present during testimony against him and to ask questions of witnesses.

When Ms. Rex finished testifying, Mr. Tell asked whether he could now ask some questions. He then did essentially ask three or four questions by way of cross-examination, albeit largely in the form of declarative statements serving the useful purpose of making the point that his plans for discharge were not as confused as Ms. Rex had represented. Rather, she had simply misunderstood that when he referred to "going to Washington to talk to a man," there were two men, one in Seattle and one in Washington, D.C. Each had a role to play in arranging for the patent that Mr. Tell was seeking. During all of this exchange and during Ms. Rex's testimony, Mr. Tell had been sitting only a few feet away from her, composed and yet poised to engage her, in control and yet coiled and tense. He had greeted her and smiled toward her in the manner of a man who was seeing a long-time social companion.

The next witness was Mr. Tell's nephew David. Like his uncle, David Tell was tall and good-looking. He was much younger, approximately 20 years old, and far more relaxed and seemingly at peace with himself. He was less volatile and waited for questions to be asked, rather than seeking continuously to engage those around him and to control the situation in which he found himself. He described prior visits by his uncle on three to five other occasions, saying that this time "he's different." Before, Mr. Tell had been more quiet and subdued. This time "he was off the wall." He described an instance in which Mr. Tell had stopped a lady on the street for a cigarette light and had been flirtatious with her, which was not like Mr. Tell. Over the course of his visit, Mr. Tell's conduct "got worse." There had been an incident at a wrestling tournament, which drew another objection when David said that he had not been there. However, there had also been an incident in which Mr. Tell took David's leather jacket and boots as he was packing to leave, and had thrown a glass of water in David's face when David requested their return. The water, Mr. Tell said, was part of his effort to "call David to Christ."

Shortly after this incident, Mr. Tell was taken to the hospital. There Mr. Tell had tried to learn the first and last names of a female staff member. When she declined to disclose her last name, Mr. Tell had asked her if she was afraid of his raping her. This kind of hypersexuality, David said, was out of character for his uncle. At the hospital, Mr. Tell became upset and destroyed some pieces of equipment. He continued to be agitated. Today, as he sat in the hearing room, Mr. Tell seemed much closer to his normal behavior and composure.

With that, the testimony concluded. The brother, sitting in the hearing room, declined to testify. He presented an interesting contrast to Mr. Tell. Where Mr. Tell had a full head of hair, the brother was largely bald. Where Mr. Tell sat in a Hawaiian aloha shirt (to which Mr. Tell had alluded while his nephew was testifying, prompting the nephew to say "Cool shirt"), the brother sat in a tan corduroy sport coat and a dress shirt open at the neck. Where Mr. Tell was continuously alert, engaged and controlling, the brother sat quietly, visibly concerned about the proceedings but declining to participate. What perhaps was most intriguing was the contrast in physical appearance. Mr. Tell's face showed tension, fatigue, almost an animal-like intensity, while the brother's face showed the same effects of aging—bags under the eyes, lines in the face, the roundness of flesh of middle age—but reflected a person who was more at ease, balanced, at peace. Looking from one to another, it was almost possible to see a Jekyll–Hyde contrast, or perhaps the kind of contrast one might expect going from Dorian Grey to the portrait of Dorian Grey.

Mr. Tell's testimony began easily enough. He was upset at the hospital because he had thought he was going to see a counselor; instead, he had been "tricked." He had not really destroyed much property, but instead had inflated some surgical gloves and "popped them" with, as he confirmed with his nephew, now in the audience section, the kind of noise a gun might make. In his recitation of detail and motivation,

point, as the younger and nearer of the two psychologists questioned him, Mr. Tell admitted that he had a special power over women, a sexual power. He enjoyed it and they enjoyed him. The force with which he recited this belief was considerable, although he quickly added that he would never rape a woman or force her to do anything that she did not want to do. But he had that power. Didn't she feel it?

At the conclusion of all of the testimony, I received the psychologists' reports. I can recall no other occasion where the reports were in such disarray. The older psychologist concluded that Mr. Tell should be committed. He was, she noted, a danger to others and unable to support himself. The younger psychologist concluded that he should not be committed, although her report form indicated that she had first concluded that he should be committed, then changed her mind. She agreed that he suffered from a mental disease or defect, but she could not conclude that he was a danger to himself or others or unable to care for himself.

On the record as summarized here and in the light of these reports, for the first time in my experience I said that I would not decide the case at that time but instead would pass the case until later in the morning, while I took testimony on other cases. Mr. Tell's objective conduct did not justify commitment, but his emotional state, barely under control and at all times bursting through, seemed to pose a danger to himself and to others. Yet in the presence of such a personality, it is difficult to analyze and reflect upon the interface between fact and statute. Indeed, it is difficult even to decide what "fact" is.

When we returned to the case, Mr. Tell was brought back into the room. He was bright and chipper and inquired as to whether he was now free to go. The investigator, who had testified earlier and who had obviously been reflecting on the case in the interim, added a few comments on the record. They proved crucial. Essentially, she said that he was signifi-

Mr. Tell made sense. But, as often happens, left to talk without interruption, he began to lose control. And so, he added that he was a Kung Fu master and an expert kick boxer, that he had told this to one of the police officers there, and that he had seen in the officer's face, as the officer retreated, a sense of appreciation for Mr. Tell's power. But of course Mr. Tell never uses that power.

He was in control in the hospital. It had not been necessary to restrain him. Indeed, he had a wonderful conversation with a beautiful Portland police officer, about love and marriage, and she had been able to drive him alone from one hospital to another. She was the one, he said to his brother, who had the freckles. Remember? She loved him, he was sure, dearly. At this point it was difficult to know how much of what Mr. Tell was saying was irony and how much he truly believed.

The boots and jacket incident was, Mr. Tell said, "a parable." He had wanted to instruct his nephew in the ways of Christ, who had taught that if one takes your shirt, you should give him your jacket as well. When he threw water on the nephew, he was baptizing him. It was Christ's special mission, and hence Mr. Tell's, to save the earth. He had talked with Christ in a dream, and Christ bowed down to Mr. Tell. Later, Mr. Tell returned to this idea that he had a special relationship with Christ and a special mission to discharge Christ's responsibilities in this world. Mr. Tell's former wife had not "sent him" to Oregon. But she had helped him to buy a ticket that had been for sale in the newspaper, going with him to the airport and signing her name as the female passenger. He had employment in Virginia, where he was a house painter. The last job was a $5,000 job, for the best house painter in Virginia to paint the house of the best surgeon in Virginia. He could return and resume painting at any time. The contractor trusted him completely.

And so it went. When the psychologists asked Mr. Tell questions, he turned his considerable charm on them. At one

cantly worse than when she saw him at the hospital. His manner, his affect and his self-awareness had all deteriorated. She simply wanted us to understand that a change had taken place and that it had been for the worse. With that, the younger psychologist asked if she could make some changes to her report. I returned her report to her, and while she was making the alterations, I passed a note to the district attorney, instructing him to alert the security guard that Mr. Tell was "going away and to be very careful in the next few minutes." When the psychologist returned her report to me, she had again changed her conclusion, recommending, finally, commitment.

That was the decision. I told Mr. Tell that the psychologists were in disagreement on most points: whether he was a danger to others or himself, or whether he was able to care for himself and his basic needs. However, they agreed that he should be committed. I concurred in that conclusion and, frankly, shared the ambivalence of the psychologists, but I was concerned that if released, he would pose a significant danger to other people and, as his condition progressed, be unable to provide for his basic needs. I then said that I thought he was not surprised to learn that he would be returning to Dammasch. At this point he interrupted me and said, "No," that actually he had been there once before, years ago, and that it had helped him. With that, instead of the physical confrontation that I feared and anticipated, Mr. Tell was led calmly, almost happily, from the room.

Thus he added one more bit of confusion to this picture. If he was truly a man out of control, presumably that would never have been more likely to be evidenced than when he was being told that he would be kept in custody and transported to a mental hospital. Yet in a way that raised serious doubt as to the correctness of the decision, he maintained his control and his affability. As he left, an inaudible sigh of relief seemed to go up from the hearing room. People relaxed visibly. Other respondents in similar proceedings had been agitated, strung out and wound up, on the edge of control or, indeed, out of

control. However, none seemed quite as capable of filling a room with dominant, pent-up power as Roland Tell. In another time, in other circumstances, that very capacity might lead a nation—but whether it would lead the nation to greatness or to destruction is open to question.

One factor that may have enabled Roland Tell to go gently into custody was his reaction to my treatment of him during the hearing. For a number of respondents in commitment hearings, it comes as news that they have rights, that they may participate in the hearings, that they will hear witnesses and may ask questions of witnesses, that they are participants of equal dignity with the mental health professionals and the attorneys around the table. For a number of these people, it may be the first time in the mental health process, perhaps the first time in a long time in their lives, when they have been treated as autonomous, competent individuals. For example, after the explanation to Roland Tell, he commented that we do things differently in Oregon from the way they do things in Virginia. I could have let that pass, but instead I asked him what he meant. Partly, this kind of questioning at the outset is a way of learning whether the person is understanding what is being said. Partly, it is to encourage the person to believe in his/her right to participate. Mr. Tell responded that it appeared that in Oregon we respect civil rights and take things a step at a time. This was not true in Virginia. He preferred our approach in Oregon. It may well be—indeed, it is my belief—that the way these hearings are conducted has a profound impact on the way people view themselves and on whether or not, ultimately, a commitment will succeed.[91]

Tell's case was difficult for several reasons. He had no clear defect or disease; it was not clear that he *would* harm himself or others; he might well have been able to care for himself. Yet the *trend* seemed otherwise, and the changes in his behavior were palpable and troublesome. Equally troublesome was the palpable, *felt* impact he had on other people.

This, coupled with his grandiose delusions, argued powerfully for commitment. Nevertheless the grounds, under the statute, seemed thin indeed.

Mr. Tell represents a type of person often considered for commitment—troubled and troubling, yet not clearly over the edge. Another type—a person who is already in the web of agency or institutional services and processes—is represented by Mary Patrick. What happens to such people, the ways in which agencies impose on them, are often cause for genuine concern and may well serve as a reason for *not* committing someone like Mr. Tell. The agencies are understaffed, undertrained and overworked. Often the issue becomes not care but conformity or control, and the resisting citizen finds she faces commitment.

Mary Patrick was such a person, although agency mishandling was difficult to establish. Instead, like Tell, Ms. Patrick seemed an ordinary person in jeopardy. Like Tell, she shared a religious vision typical of many who come into the commitment hearing room. Except for that, however, she was a very different person.

Mary Patrick was a slightly built woman who appeared 10 years younger than her 31 years. She was dressed neatly and attractively, her hair and clothing groomed appropriately. After I explained to her the rights that she would enjoy in the hearing and the procedures we would follow, she commented that she understood all of this. She was not a manic depressive, although she had been falsely accused of this. Rather, she was simply stressed out and experiencing the effect of lithium, as well as of PMS, for which they refused to treat her at the hospital. Although she expressed a concern, often voiced by those who have been held in a hospital prior to a hearing in court, that her appearance was disheveled or unpresentable, she nevertheless fit neatly among the persons arrayed around the conference table. She indicated that she had received several medications over the preceding few

days, but on the day of the hearing, she had only taken lithium. She seemed bright, and her choice of words was excellent, but her speech was somewhat rambling and discursive, which she attributed to a heavy dose of lithium. She went on to say that she had a house and a volunteer job, and that we could call the head of the Volunteer Bureau. She gave us the telephone number of the Volunteer Bureau, as well as the telephone number of her parents, who she said would not be in court that day.

The picture that was presented, of a cooperative if overeager woman, was in sharp contrast to the picture presented in the precommitment investigation report. There, a police officer's "hold" related that one of the area mental health agencies had contacted the officer to meet a case worker in front of some transition projects in town. These projects are social service agencies that assist transients, street people, and the homeless, providing them with support services, food, and shelter. The precommitment investigation report stated that when the officer arrived, he found the respondent there, dirty and barefoot, wearing shorts, and with a cut on her leg that needed attention. He stopped her and took her into custody.

The precommitment investigation report itself, done by Lawrence Wren, repeated the observations of the officer and went on to say that Mary Patrick had been a "client" of Northeast Mental Agency. Approximately four months before, she had refused to continue taking lithium. Her parents became concerned and went to Ms. Patrick's apartment, where they found her frightened that a boyfriend was returning to do her harm. They took her to their home, which Ms. Patrick subsequently left. The report stated that, according to her parents, Mary had "torn up" her apartment.

Essentially, that was it. The parents had been concerned; the young woman had trashed her apartment; she had been found in a high-risk area where a young single woman ought not to go. The police therefore picked her up. She had been held in

custody for five days, and now she was to be presented on charges of being mentally ill. Ms. Patrick seemed remarkably composed, and any ordinary person—the reader or author of this article, say—might have been shaking with indignation.

Lawrence Wren testified. He said that when he spoke with Mary Patrick previously, she was highly agitated. It had not been possible to carry on a conversation. She never "fully understood her own status." The information received from the parents could not be testified to, since it would be hearsay; moreover, Mr. Wren stated that the parents were not there because they had expected the case to be set over to another day. Instead, Mary Patrick, on the day of the hearing, insisted upon going forward. Thus his observations and the description of her condition were necessarily limited. In his opinion, Ms. Patrick needed two or more weeks to stabilize. When she went off her medication, there was substantial deterioration, and if it continued, she would "decompensate." She needed "insight," especially as to medication.

During Mr. Wren's testimony, and subsequently during that of the officer, Mary Patrick kept a running commentary going. It was in a half-voice and it was coherent, but it was nevertheless disturbing and interfered with my ability to hear Mr. Wren's testimony. However, it was not loud enough or angry enough to disrupt that testimony, nor did it indicate that Ms. Patrick was out of control. It did indicate a sense of urgency to be heard and to rebut the comments the witness had made. Such urgency to rebut is not uncommon, and in an important way it indicates that the respondent is in touch with the proceedings, the testimony, and the circumstances of his or her situation. Although I spoke with Ms. Patrick about her comments, she was only partly able to restrain herself, and the commentary continued throughout the remainder of Mr. Wren's testimony.

Mr. Wren continued that he had explored placements for Ms. Patrick. Portland Adventist was not willing to take her,

nor was the Ryles Center. He felt that Mary Patrick simply "could not make it out there." She would not last more than "a day or two" before being brought into a hospital. When he interviewed her, he had encountered "pressured speech" that was transitional, exhibiting no judgment and no insight. Essentially, Mary Patrick felt she had been "jerked around by the system." She needed to be cared for, at least for a few weeks.

The psychological examiners and the defense counsel both questioned Mr. Wren. The respondent had indicated no homicidal or suicidal thoughts. Mr. Wren had not himself seen any tearing up of the apartment. The reason that Mary Patrick gave, confirmed later in the hearing, for not taking lithium or other medications was that they tended to make her ill. He could not describe Mary Patrick's manner, symptoms, or characteristics two weeks, two months, or two years previously, since he was not the case worker or case manager who had continuing contact. There was none of the marked, dramatic deterioration that had characterized Roland Tell.

When Mr. Wren finished, and before the officer testified, I reflected upon his testimony. Perhaps it was overly simplistic, but this was a young, attractive white woman, with a quality of vulnerability about her, who was found in a racially mixed, lower socioeconomic and troubled area of town. Perhaps she had taken to going there routinely. Perhaps her Irish-Catholic parents, indeed the white majoritarian view of the social services agencies, were upset, even affronted by the notion of such encounters. If a man had visited Portland's Skid Row, I could not help but wonder, would he be charged with being mentally ill? If Mary Patrick had been black or Hispanic, would anyone have cared?

I also wondered, as I have in other cases, why the case manager was not present to testify. She and Mary Patrick had obviously had a falling out. But, if we were to believe that Mary Patrick was mentally ill, that is not uncommon. The

best witness and the best testimony concerning Mary Patrick's condition and her deteriorating state could come only from a person who had worked with her over a period of time. Yet no such testimony had been or would be offered. When I inquired as to why the case manager was not there, Mr. Wren stated that the manager felt her testifying against Mary Patrick would simply jeopardize their relationship. I thought to myself that this was rather prejudging the outcome of the hearing; after all, there might well be *no* future relationship. Moreover, it could hardly have escaped Ms. Patrick's attention, since she was sitting 10 feet away from Mr. Wren, that the commitment proceeding had been initiated with her case manager's approval and active participation. The case manager's presence in the courtroom was necessary not only as an evidentiary matter but as an exercise in honesty.

In Mary Patrick's case, the case worker never testified. The parents never appeared. The best evidence, indispensable to sound decision making by the court, was never produced. Instead, in addition to Lawrence Wren, the only other witness was Officer Walters, a young man of average height and build, with an attractive face and manner. As he sat on the witness chair, some 10 feet from Mary Patrick, she brightened up and cheerily said, "Hello, Officer." He responded by saying hello to her. His testimony essentially confirmed what was in his "hold" document. He had met Mary Patrick's case worker in front of the transition project on Burnside. Mary was walking away, dirty, barefoot, with a "male Hispanic." When he stopped her and took her into custody, she seemed to understand why he was there, and she was only a little hostile.

As I listened to the testimony, it seemed to me ironic that the case worker would feel she could summon the police and make an arrest on a public street in broad daylight without jeopardizing her relationship with Mary Patrick, yet feel that if she appeared in a courtroom for the minor irrelevancy of

describing why Mary Patrick needed to be committed, this might jeopardize their relationship.

Officer Walters went on to say that Mary Patrick's mood seemed to be "up and down." As he drove her to Portland Adventist Hospital, she talked to herself quietly in the back of the car. Sometimes he could hear what she was saying and it made good sense, about volunteer work and other such endeavors. Other times, it did not make sense. Some of the commentary had to do with staying up for three or four nights and not eating because she was afraid of an old boyfriend. Some of it had to do with the case worker lying about her and accusing her falsely.

While Officer Walters testified, Mary Patrick interjected comments. She had not, she said, been talking to herself, but had been talking softly to Officer Walters. She had been making a number of comments to try to persuade him to let her go. If it seemed disjointed, it was only because she was upset. The interjections in Officer Walters' testimony were relevant, the timing was tolerable, and although Ms. Patrick interrupted Walters' testimony, it was not in the nature of interference.

On cross-examination, Officer Walters said that Mary Patrick had not posed a threat to anyone other than herself and that the only threat to herself, as far as he could see, was that she lacked good judgment and needed help. Nothing indicated that she had hurt herself or would hurt herself. The wound on the leg was more like a shaving wound than anything else. She had said that she was afraid of her boyfriend and was going to stay the night at a shelter in the transition project. In response to my question, Officer Walters did say that on the day when he picked up Ms. Patrick, at which time she was barefoot and wearing shorts, the Portland area had been experiencing unseasonably warm weather and so the clothing was not inappropriate. Nor, except for her appearing dirty, did her grooming seem inappropriate.

Mary Patrick then testified. She began by saying that various people were lying and that she could not trust her parents and that she was angry with the people at the hospital. She referred to it as "a righteous anger." She was afraid of her parents, who, she said, had been abusive of her. She had not torn up her apartment, but had simply been cleaning it up and putting things in order, assembling a number of objects to give away. She went on to say that her life was in jeopardy, it did not matter from whom, but that her parents were threatening her and that they had tried to isolate her.

Mixed with this rather rambling and perhaps paranoid commentary were a number of factual assertions. Ms. Patrick said that she had had an apartment for four years, that the rent was $225 a month, and that by watching her money closely she managed to survive. She received Social Security disability, and her parents were the representative payees. She did not like that, but it worked. She had no problem with an ex-boyfriend, although on the night when her parents broke into her apartment, she had heard noises outside and was afraid that somebody was trying to break in. She had therefore gotten into her bathtub and taken out her Bible and read loudly from it. She had "come to Jesus" recently and was relying on Him.

One of the recurring difficulties in these hearings became apparent at this point. There was simply no way to corroborate or confirm Ms. Patrick's factual claims. Did she have an apartment? Was it a nice place? Did her parent serve as representative payees? Did she have a volunteer job? There was no other witness who could testify in support or denial of these claims. Neither the district attorney nor the public defender, both of whom had received the files only half an hour earlier, had done any investigation. The case manager, the person best informed and best able to help the court, was not present. In dozens of other cases, in varying ways, witnesses and evidence were missing on important issues necessary to commitment.

As a result, the judge is left wondering what the truth really is. In terms of decision making, the judge is left to rely upon the rules of law that say that the burden of proof is on the district attorney, and the decision must be against commitment if the burden is not carried.[92] However, the life and welfare of a Mary Patrick are not abstractions, and a decision for or against commitment should not be made to turn upon agency mismanagement, prosecutorial indifference, or defense's ineptitude. Burdens of proof favor the respondent, but only as legal abstractions, not as reality findings.

As Ms. Patrick testified in response to open-ended questions, there was a rambling quality to her testimony, and inconsistencies developed. She said that she would never return to a mental health center where she had stayed; later she said she would. Earlier she said that she would never again work with the absent case manager; later she said she would. Despite these inconsistencies, however, her basic thesis was cogent and coherent: she had an apartment, she had a volunteer job, her parents and she did not get along, and she was being "jerked around" by the mental health system. When I asked her about the "abuse" by her parents, her anger flashed, but it appeared that the threats consisted of the parents' saying that if she did not continue to take her medication, she was going to have to go back to the hospital. She insisted that lithium was bad for her, and that even as she sat in the hearing room, she was having difficulty with the heaviness of the dosage she had been given.

The most important answer to the most important question, where would she go that night and where would she stay, remained consistent. Mary Patrick had a place to stay. There was income available to her. The rent was paid. She would have a place to eat and sleep. She could go home.

The psychological examiners questioned Mary Patrick at some length. Nevertheless, many of the qualities of mental illness, observed in other respondents, simply did not emerge.

Although she was angry, defensive, rambling, and inconsistent, she nevertheless kept all of that within fairly close bounds. While she occasionally made references to being an "evangelist" for Jesus, she did not seem to have a view of herself or of God as working miracles or of having power to move forces. She did not hear voices. She was simply a young woman with possibly impaired judgment who consequently was at some risk.

The psychological examiners' reports recommended commitment. It was rare for me to disagree with the psychologists when they were in agreement. But I did, nevertheless, and took some time to think about it. It is difficult to say exactly why I declined to commit in Mary Patrick's case. It would be easy to say simply that the state must prove by clear and convincing evidence that Mary Patrick is a danger to herself or others or cannot provide for her basic needs, that the evidence was not clear, and that I was not convinced. Perhaps the strongest evidence of need to intervene and commit was circumstantial, in the form of agency concern and police action. The implication was that this woman had been the subject of agency attention and control for 14 years and here she was, acting out again. The agency's instinctive reaction was to take control and lock her up. It had been done before, so why should it not be done again? This "churning" of citizens by agencies is not unusual, reflecting a felt need to control people once they are brought into the mental health system. Whether it serves the person's needs or the agency's becomes difficult to distinguish. But if the agency or system does not take courts seriously enough to present its best evidence for commitment, no judge should be co-opted into acquiescence and instead must insist on a burden of proof, which, in the end, is designed to protect civil liberties.

When Ms. Patrick was brought back into the hearing room, she apologized earnestly for perhaps having "barked" at someone and also apologized for her appearance, which she described as that of a "scrud." I explained to her the examin-

ers' report and my conclusion that despite their agreement, I was going to enter an order of discharge. She asked what that meant, and I explained that it meant she could go home that day. She thanked me and then left, returning later to shake my hand and again thank me directly.

Upon discharging her, I said to Mary Patrick that her principal difficulty in providing for her basic needs was her relationship with her parents. They control her money, they trigger agency processes, they break into her apartment to see how she is doing. Without having met them, I said to her, I suspected that she and her lifestyle were terribly upsetting to her parents. Mary Patrick agreed that all this was true and said she would try to do better. As with Roland Tell, Ms. Patrick expressed the view that the hearing had been fair and that the treatment of her had been positive and valuable. In her case, since she was not committed, it may be suspected that there was some self-interest in the conclusion. Yet her participation during the hearing and her reaction afterward reflected the sense of a person who was being treated with care, deference and dignity. At the end of the day, when she was leaving, having picked up her belongings from the holding room next door, she came back into the hearing room and approached me to say thank you, appearing to intend giving me a hug. I shook her hand, rising only half-way, and wished her luck. The psychologist sitting next to me said she thought that if I had risen farther, I might have received a kiss.

Nancy Victor's hearing also resulted in discharge. Yet the notification of mental illness had stated, cryptically, that she was in need of treatment because she was "psychotic/delusional" and, on the next line, exhibited "noncooperation with therapy." The attached precommitment investigation report indicated that she was a 35-year-old woman who had voluntarily approached several emergency room departments of local hospitals complaining of pains in her stomach and other feelings, and was finally admitted to Woodland Park Hospital. About three weeks later, a physician signed the physi-

cian's "hold," ending her voluntary treatment. Lawrence Wren's report related that Ms. Victor had an apartment in Olympia, Washington, but could not say how she would get there or how she would care for herself when discharged from the hospital. She had recently lost her grandmother; since coming to Oregon from Olympia, she had lost custody of her only child, age 10, to the Children's Services Division of Oregon. According to the report, her mother stated that Ms. Victor had had her first hospitalization about a year after the birth of her child. Ms. Victor's five-year marriage had ended in divorce. She had worked as a nurse's aide and as a waitress, and although she had dropped out of high school, she had obtained her general equivalency degree.

Nancy Victor, as she appeared in the hearing room, reflected many of the expectations the precommitment report created. She looked her 35 years, slight of build and badly worn, yet her attention was engaged as I recited her rights and the procedures we were to follow. Her posture straightened, and she thanked me for the recitation. When I asked her about the medications—Valium, Prolixin and others, all of which the report said had been administered to her—she answered slowly and thoughtfully as to kinds and quantities. When I asked how she was feeling and what the effect was of these medications, she said that she understood the medications were good for her. She had stopped taking them for a while but would continue to take them in the future. She did say that if she were not "drugged" at this time, she would have more energy and she would be happier.

The investigator, Lawrence Wren, testified in Ms. Victor's presence. As on most other occasions, he spoke as though she were not in the room, as though she were not sitting to his left, only a few feet away. Being treated as a thing—indeed, as an absent object—if systematized and repeated often enough might alone drive people mad. Often that type of testimony produces interjections, responses, or arguments from the people who are the subject of the proceeding. Mr. Wren

essentially recapitulated what was in his report, saying that he had given Ms. Victor an opportunity to locate friends in the State of Washington who would help her support herself, to contact the manager of the apartment building where she said she had an apartment, and to contact her mother. She had failed to do any of them. She was "paranoid about her family" and was able to say nothing about her friends. She had been seeking care through emergency rooms, saying that she felt she was pregnant, although tests were negative.

At the outset, the public defender had stated that Ms. Victor had a friend, Diane, who would meet her in Washington upon her return by bus. Ms. Victor interrupted Mr. Wren's testimony to repeat that. Ms. Victor's speech was slow, but coherent and intelligent. Her choice of words was excellent. She described Diane as a church acquaintance who was very caring and had in the past acted on Ms. Victor's behalf. To this, Mr. Wren said that he had had no opportunity to check out the new information. He would, however, be willing to do so.

In response to my questions, Mr. Wren was unable to say how much of Ms. Victor's appearance in the hearing room was due to her underlying condition and how much was due to the medications. She was taking the maximum dosages of Prolixin and Cogentin. One was designed to suppress psychosis and hallucinations, the other to deal with side effects. There was no baseline to gauge how much of Ms. Victor's slowness was due to the medication and how much was due to her mental disease. Moreover, there was no way to tell how she would be in the absence of medication. Without such medication, she had traveled from Washington to Oregon and had functioned in Washington for a number of months or years. With it, she was in a hearing room, subject to a mental commitment proceeding. There was no way of knowing whether the medication was helping her or hindering her.

The doctor, as always, was absent.

Mr. Wren also could not say why the hospital had initiated involuntary commitment proceedings. Nancy Victor had gone there for care and assistance. She had not created any problems. The care had been given for several weeks, and there was nothing more, Mr. Wren said, that Dr. Smith felt he could do. Why, then, I asked, had he not simply arranged for Ms. Victor to be transported back to Washington? Mr. Wren said that was not customarily part of a hospital's responsibility.

The psychologist, Dr. Boston, asked why it was that the hospital had signed a "hold." Mr. Wren's answer confirmed that Ms. Victor was preparing to leave, and although she had made no overt effort to depart, the hospital was concerned. The reasons were not specific. There had been inappropriate laughter, religiosity, and reports of auditory hallucinations. A hold would "allow for resolution" of the treatment at the hospital.

Prior to leaving Olympia, Washington, he was asked, had she been able to care for herself? The answer was, apparently so. Ms. Victor had a one-bedroom apartment at $470 a month rental. Her Social Security check was on the order of $650. She was able to care for herself, and apparently there might be people in the community who would help her.

Ms. Victor then testified. She was coherent and comprehensive in her comments, although somewhat discursive and occasionally hostile. Her parents had been abusive toward her, so she would not call them, although from time to time she did, and they would pay her rent to keep her apartment current. She had not taken her medications for two months a few months before because of her unhappiness about their impact, but she realized now that was a mistake. She would take the medications daily because "if I don't, failing to do so messes me up." The abuse by the parents, which she later said was both mental and sexual, provided the reason for her traveling to Oregon. She was scared for her daughter.

A commitment hearing with respect to the daughter was scheduled three days after this hearing. If released, she would return to Olympia for that hearing.

Ms. Victor felt she could make it on her own. There was an apartment, there were friends, and there were medical services available to her. She had been seeing a family practitioner, to whom she would return for a referral to a psychiatrist, replacing the one whom she had been seeing. She felt she could function with her medications, although without them she was possibly manic depressive. She had never been committed, although in Seattle a hold had been placed against her for three months. However, a few years before she had been sent to a mental health center in Olympia. At no time had she heard voices, except for a brief time after electroconvulsive therapy at Mountainview Hospital in 1989. In response to my questions, she said that the voices were strongly impacting her, that they were from the enemy, satanic. The voices said things to her. When I asked whether the voices seemed "real" at the time, she paused and said, reflectively, that that was an interesting question. Her answer was that the voices did not seem real, in the same way our voices did.

If we had released Nancy Victor from the hearing room and told her to walk out the door into the corridor of the courthouse, she would not have had a clue as to where to go. Once outside the door of the courthouse and on the street, she would have been lost. There was no place to go for that evening, not even a place to go for lunch. Ms. Victor would have had to go back to the very hospitals that had brought her into the courthouse. She was quite obviously unable to provide for her basic needs.

Nevertheless, 100 miles away there was an apartment, there was a family, there was medical support, and there were friends, at least on report. No one had checked these out.

Nobody had mobilized them. Nobody had come up with a bus ticket to Olympia. Nobody had done their job.

It may perhaps seem unfair, perhaps even too easy, to call this a failing or a failure. Nevertheless, the district attorney was seeking to commit Nancy Victor at a great cost of liberty to her and at a great financial cost to the taxpayers. The investigator for the mental health agency was pretending to have done an investigation and to have reached a conclusion that required commitment, when the obvious conclusion—returning Nancy Victor to Washington—was nowhere even noted in his report. The public defender was pretending to represent Nancy Victor, yet neither he nor his staff had contacted her friends, her family, or her physicians in Washington. In the most trivial of misdemeanor criminal prosecutions, defense counsel would develop and offer alternative dispositions. In this most serious of matters, he offered none.

The authority of a judge in such a situation is severely limited. My three choices were to discharge Nancy Victor, in which case she clearly would be unable to care for her basic needs; to undertake a conditional release, as to which there must first be someone willing to receive her; or to commit her to a mental institution in the State of Oregon, where upon her release there would still be no place for her to go and no way for her to provide for her basic needs. She could then be returned, again and again, to the same mental hospital in the same community where the same incapacities would remain ever true.

Instead, I chose a fourth option: Nancy Victor's case was continued until the following Monday, with the state to provide shelter for her until that time or until such time as the public defender and district attorney assured me, by telephone, that a bus ticket had been arranged, that people would meet Nancy Victor in Olympia or Seattle, and that they could confirm that her apartment and her family were waiting for her.

The call came at 2:30 that afternoon, and I traveled to the courthouse from the law school, delivering an order of discharge to a bus that left at 3:00. In the lockup, as I passed her prior to her boarding the bus, Nancy Victor looked up and thanked me.

The relationship between citizens and the mental health network, as the preceding cases illustrate, complicates a court's task enormously—affecting standards, testimony, the very appearance of the respondent herself. Frequently people who have been considered for commitment proceedings are diverted through family or agency intervention. Thus the commitment proceedings most often concern people lacking those options, as a result of which they have been in custody, often restrained and often medicated. The screening makes it difficult to discern these respondents' true condition through the lens of anger and drugs and to set them, for comparison, in the spectrum of others more fortunately screened away.

Thus, as Nancy Victor's case demonstrates, much of what happens in an ordinary case is powerfully affected by the immediate situation of the respondent, just prior to three or five days of confinement, restraint and medication, and just after—upon presentment in the courtroom.

B. Then, some people hear voices

Many of the people who come before the court for mental commitment hearings are simply passing through a time of high stress and difficulty. Alcohol or drug abuse may accompany that experience. As a result, their lives may fall into disarray and cause them to behave aberrantly. Civil commitment processes may in fact be quite helpful for such people, essentially giving them a "time out." Such people are not "crazy" in the way we usually use the word. They do need help, but that need is a transitory one.

The same observations may be made of many of the people who appear subject to medications they received the night or the morning before the hearing. The most frequent medica-

tion is lithium, accompanied by, in many cases, various tranquilizers. The dosages vary. The frequency and the recent nature of the administrations vary. The impact seems obvious in many instances: the person appearing in the courtroom is slow of speech, very relaxed, almost ethereal and inappropriately reflective. Intelligence does not seem affected, but the capacity to interact in a normal time frame clearly is. Such people may appear to have a mental defect, albeit not a crippling one. Indeed, when they have been medicated, their conduct and demeanor are frequently far more affable than the conduct described in the papers that brought them to court. However, the medication and its impact on them means that as they sit in the courtroom, it is quite impossible to assess how they are in their normal lives and how their normal lives would be conducted absent medication.

Still, the hearing room frequently is occupied by people who slowly manifest themselves as being truly crazy. From a layperson's point of view, "craziness" can show itself three ways, frequently all at once. First, the people may perceive their surroundings or other people in ways that are not normal. Indeed, their perceptions may be bizarre or wildly inappropriate. Second, they may interact with people in a manner which might be effective and appropriate, but the interaction slowly brings out a basic failure of knowledge or ability, so that the person's efforts are out of touch with reality, at least as we know it. Third, and most troublesome, a person's self-perception and estimation may be out of touch with reality, as when he or she experiences persecution, powers, or a personal history (or potential) that is simply untrue.

If a young man says that he has started up a telephone company, it is always possible the young man did do that. If a young woman says that she hears voices in the night, it is always possible that there have in fact been voices in the night. The precommitment investigation reports frequently include only a very limited interview with the respondent, with the people in the hospital where the respondent is being

held, and with prior case workers or their files. If the present caretakers and the past caretakers, by speaking only with themselves and seeing the person only in a time of crisis, have concluded that the person is crazy, the investigation will only confirm that circular conversation.

In a criminal courtroom, the process would look to the public defender to take days or weeks to prepare a response, an investigation, an alternative to incarceration, and perhaps even a defense on the merits. Yet typically, in the precommitment hearings, the public defender has just met the person that morning. The public defender has had no opportunity, no time, and no resources to do an adequate investigation. The same is true of the psychological examiners who sit in the courtroom. The same is true of the district attorney.

In the worst of all possible ways, the crazy person and the judge are alone on a seesaw.

The psychological examiners have told me that a beginning interchange between the judge and the respondent is quite useful to them, although they themselves will subsequently conduct a more clinically grounded psychological inquiry into the person's basic orientation. Such interactions, coupled by subsequent testimony that the person may choose to offer, sometimes will reveal a person who is in fact truly crazy. In a normal setting, in a social group, in a workplace, many of them could pass for a while unnoticed. Indeed, many people who are truly mentally ill can function in the community and are returned to it after they are committed. To a considerable extent, the question of commitment turns less upon whether the person is mentally ill than on whether we provide adequate resources for that person in the community. However, with those who are profoundly disturbed, the principal inquiry relates to psychological, even organic, disabilities. These may be pervasively crippling.

Peter Black was a stocky, attractive man who appeared younger than his 45 years. The diagnosis was bipolar, manic. He had 10 prior commitments to a state hospital. The precommitment investigation report said that he had been picked up, confused, speech not tracking, after an incident with a police officer. Thus he was on a "police hold." The police officer's report said that Mr. Black had talked about being a member of the Israeli Secret Service and the KGB. As it turned out, the latter reference was inaccurate. Nevertheless, Mr. Black did maintain that he was a member of the Israeli Secret Service, which he described as the Mosad. He denied knowledge of the KGB.

The precommitment investigation reported that Mr. Black's case manager despaired of helping him. She had twice arranged for him to get an apartment, with a $125 deposit, and in neither instance did he follow through. He also failed to follow through on other arrangements for care. She was quoted in the report as simply feeling that she was now "enabling his decompensation." She had checked with his "prior team," and he needed long-term care in the state mental hospital. Had she prepared the investigation, and had she been available for testimony, the court would have been provided with her direct observations and her long-term experience with Mr. Black. Instead, another person in a different section of her agency prepared the report. Thus the court was deprived of the case manager's insights, experience and conclusions, and instead was left with double or triple hearsay.

We did, however, have Mr. Black himself. While his rights were being explained to him, he interjected several times. The interjections were bright, perceptive, aggressive and witty. They were also a bit odd. At one point, he wanted to know whether this was a "trial or a hearing." After some reflection, I answered that it was both. He seemed satisfied with this. When I told him that he had a right to cross-examine witnesses, he asked if that really meant that he could question Mr. Cole, who had prepared the precommitment

investigation report. I replied that it did mean he could ask questions. Later, when the opportunity arose, he asked Mr. Cole and one of the psychological examiners whether they were members of the Communist Party and out to get him. He posed other questions, equally odd.

During his own testimony, Mr. Black revealed that he thought he was running for the United States Senate, or possibly the Congress. He wanted to cross-examine the precinct patrolman, through attorneys whom Amnesty International would provide. There were considerable quickness and humor to his commentary, which included national and international affairs, but he could not stay with any one subject, and many of the subjects seemed of little relevance to the immediate questions being asked him—for example, trying to ascertain his knowledge of date, place and functioning. Questions to him as to where he would live if he were released provoked commentary on national affairs and internal politics.

When I told Mr. Black that the examiners had both concluded that he needed to be committed and that I concurred, he was not surprised. He did ask whether he would be able to continue his congressional campaign at the state hospital. I responded that I did not know, but that the way things were going in the nation, I felt quite certain I would vote for him if he could continue his campaign. He smiled. He left the hearing room.

Mary MacAllister was a thin woman, long hair coming over one shoulder, with a pinched, intensely withdrawn quality about her. She sat at the end of the table, hunched forward, staring at the table before her. As I explained the nature of the proceeding and the various rights to which she was entitled, she would occasionally look up at me and I would pause and ask whether she understood what I had just said. She would say nothing. She might nod, but it was impossible to tell what the nod meant.

The precommitment investigation report indicated that she had been taken to the hospital and was catatonic. If catatonic means totally withdrawn from the external world, then Ms. MacAllister did not appear *totally* catatonic. However, if catatonic means that she was conducting herself in a way that made it difficult to have exchanges with her, she certainly qualified. She did not speak. Nevertheless, as the hearing progressed, she would nod and seemed to understand.

Mary MacAllister had no prior psychiatric history, but she had recently been evicted from the home she had occupied for ten years, not having paid rent for four years. Most recently, she had been arrested on a charge of burglary for trying to reenter the apartment and had been placed in jail. The landlord's daughter, who was in the courtroom, had arranged for Ms. MacAllister's release and had attempted to assist her. Ms. MacAllister had fled and ultimately was found standing near the police station; she was then taken to the hospital.

The investigator developed this information through his testimony. The respondent sat, looking at him occasionally and saying nothing. Her right hand would sometimes rise above the level of the table and move gracefully and, it seemed, independently, back and forth in a slow waving movement, sometimes rotating on her wrist so that her palm was facing toward her face. Other than that, Ms. MacAllister sat perfectly still.

The investigator had seen Ms. MacAllister several days before. The conversation had started slowly, dwindled, and died. In relatively short order, a matter of 10 or 15 minutes, Ms. MacAllister had stopped speaking to the investigator. The public defender was able to tell the court that Ms. MacAllister was a poet and a writer, that her journals indicated considerable accomplishment and intelligence, and that over the years she had engaged in bicycling, dancing and swimming and had cared for her body in disciplined ways.

She had been assaulted some eight years previously, and this had apparently slowly consumed her. However, the public defender added, Ms. MacAllister had ceased talking with her as well.

Mr. and Mrs. Montero testified that Ms. MacAllister had been a long-term tenant of Mrs. Montero's father. Over the previous four years, Ms. MacAllister had paid no rent, and finally she had been evicted. Mrs. Montero had arranged for Ms. MacAllister to be released from jail after the attempted burglary and attempted to persuade Ms. MacAllister to come with her to her car and to her home. Ms. MacAllister instead had fled, Mrs. Montero pursuing her for several blocks. The Monteros were prepared on the day of the hearing to take Ms. MacAllister home with them. Such an extraordinary offer requires respect. However, upon inquiry it turned out that the Monteros had three teenage children, a spare bedroom that would be barely adequate, and little or no experience with the mental health services that might be available to Ms. MacAllister. Also, both Monteros worked and would have had little time to supervise Ms. MacAllister or to assist her in pursuing community resources. Nevertheless, the warmth and concern that the Monteros expressed were truly extraordinary.

While this testimony was being offered, Ms. MacAllister sat at the table and would occasionally stare at Mrs. Montero. Ms. MacAllister's right hand would rise above the edge of the table, seeming to float in space, would fold down toward her wrist and then rise upward like the head of a swan, would pivot on the wrist into an upright position, swinging some 180 degrees in rotation, and would sometimes come forward toward her face, once or twice resting with the palm on the front of her face with the four fingers evenly divided around her nose. The rest of her was immobile. The hand seemed independently motivated.

At various times I would ask Ms. MacAllister some questions. For example, I asked whether she had listened to the principal investigator's testimony and whether it was true. She shook her head. I asked whether she recognized the principal investigator, Dr. Miles. She shook her head. As these questions and exchanges took place, I noted that her lips were moving but that nothing could be heard. I pointed this out to her. Nevertheless, she did not speak audibly.

Both psychologists concluded that a mental defect was preventing Ms. MacAllister from providing for her basic needs. Both concluded, and I concurred, that the Monteros would not be able to provide for those needs and that commitment was appropriate. At that point I communicated these conclusions to Ms. MacAllister. Her body slowly came upright. Her head slowly rose so that her eyes met mine. Across the distance of the table, her lips moved and she said something. It was not audible. I said to her that I understood she had just said something, but I wanted her to understand that nobody could hear her. Her voice rose to a whisper. I repeated my comment. The whisper became speech.

Ms. MacAllister then said that she wanted to go with the Monteros. She said that she did not want to go to a mental hospital, that she was perfectly capable of taking care of herself, and that she would follow the instructions of the Monteros. I pointed out to her that she had fled from Mrs. Montero. She said she would not do that again. I asked her why she had not spoken so that we could hear her previously. She said she thought we could, despite my having advised her to the contrary several times. In the end, despite serious misgivings, Ms. MacAllister was committed. In the brief interchange at the end of the hearing, it was clear that she was a bright and potentially effective person. Nevertheless, her behavior during the hearing was that of a person seriously incapacitated by mental illness that, because of her near-catatonic state, could not even be diagnosed, let alone treated.

There were cases where people represented a threat to others or themselves; Mary MacAllister was not one of them. She simply could not care for herself and, as a result, might well be at risk of abuse or imposition by others. This is particularly a problem for homeless or street people, discussed in the next section. In the MacAllister case, however, there was more: she was withdrawing from reality. Another—more common—pattern is to attempt to take control of reality, but in an unrealistic, manic or delusional way.

This was true of Trisal Selassi, a well-built, attractive and engaging Ethiopian of 33, somewhat balding but still with an athlete's bearing. At one point during the hearing, he commented that he kept himself in good condition by playing soccer. His speech was excellent, his choice of words was impressive, his manner was deferential, and he was at all times in contact with his surroundings. As I explained the process, the personalities, and the rights, Mr. Selassi followed me attentively and intelligently. One had to wonder why he was there.

Mr. Selassi had been taken to the hospital by his friends, who were in the hearing room. He had been hearing voices and had been wandering. He also had been making expensive purchases and living well beyond his means. His friends were concerned for him. As their testimony and his unfolded, it was clear that after four days in the hospital, he was much better. As Mr. Selassi testified, he had been unable to sleep for a number of days before entering the hospital, where he was able to resume not only normal sleep but also normal eating patterns. The investigator and Mr. Selassi's friends all testified that as Mr. Selassi presented himself in the hearing room, his condition seemed much improved over the preceding week. During that week he had lost both his job and his wife—enough to upset anyone.

The question remained, then, why was Mr. Selassi in the hearing room?

Slowly a problem emerged in terms of where Mr. Selassi could go. He did not have an apartment. He had most recently been staying with a friend, who testified that he would not take Mr. Selassi back, although they had been friends in Ethiopia since childhood. Essentially, he said, Mr. Selassi was too troublesome and could not be trusted. Mr. Selassi had no money and no support system in the community. One of the psychologists commented that until someone had been committed, he would have no case manager to support him in the community's system, and without support through the system, he would have to be committed.

Mr. Selassi himself testified that he would take any medications that were prescribed and would pursue outpatient treatment. If released, he would go to one of the shelters available for the homeless. He smiled in saying that he had never yet had to use such services, but he could do that. He said that he would hurt nobody, including himself. "Why should I?" he asked. "After all, I love myself." The lack of sleep had been precipitated by his wife's leaving him; he was basically a happy person, Mr. Selassi testified, and had worked at various jobs, which he could resume. He had never thought about counseling but would consider it. He had been to a mental hospital once, a decade before, and did not want to go there again. Mr. Selassi observed that it is, after all, a free country, and liberty is a civil right.

I noted that the precommitment investigation report had referred to Mr. Selassi's hearing voices. He said that the voices were not so much voices as they were visions. These were rather vaguely discussed, but they were forces that moved him in particular directions.

I also mentioned to him that the report quoted him as saying he was the king of Ethiopia. When I asked him whether he was in fact the king of Ethiopia, Mr. Selassi immediately responded that he was. This response took me somewhat aback. I said it was possible that he had misunderstood me

and that he simply meant he *could* be the king of Ethiopia or, indeed, some day he *might* be. Mr. Selassi said no, that he understood me, and that he was in fact the king of Ethiopia. I pressed the subject a bit further by saying that I understood the last king of Ethiopia was Haile Selassie, and, if that was true, was Mr. Selassi king in the same way that Haile Selassie had been? Mr. Selassi said *Yes*. Somewhat concerned, I turned to his friend and asked if he thought Mr. Selassi had understood me. The friend said, yes, it was clear that Mr. Selassi had, but that he would ask the same question in the language native to Ethiopia. He did and then confirmed that Mr. Selassi was in fact the king of Ethiopia.

Well, I then said, the investigation report also reported that Mr. Selassi had been making purchases beyond his means and running up credit card bills. I asked Mr. Selassi whether that was true. He said it was. I then asked, will you continue to run up bills and make purchases appropriate to the king of Ethiopia? He said that he would. We then pursued the other implications of being a king on a pauper's income, none of which seemed to inhibit Mr. Selassi.

Ultimately I entered an order of commitment, which concurred with the conclusions of the examiners. Mr. Selassi, unless we were all mistaken, was *not* the king of Ethiopia. Delusions of that sort may constitute a mental defect or illness under the statute, but they are not of an incapacitating nature. In fact, Mr. Selassi was an engaging, gregarious and intelligent young man. The difficulty was that although his delusions did not cause him to be a danger to himself or to others, they did mean that he would be unable to provide for himself and to cover his basic needs.

There was another danger as well. Mr. Selassi might well make purchases or write checks that would lead to further criminal charges. With his conception of himself, he might find that instead of being in a hearing room where the issue was commitment, he would be in a courtroom where the issue

was imprisonment. If he was able to invoke an insanity defense, he would then be processed as criminally insane. The commitment through civil processes would be far more appropriate, would prevent possible criminal prosecution, and might lead to treatment that would return Mr. Selassi promptly to the community.

There he might rejoin his followers and loyal subjects.

C. The homeless

It is not only the processes surrounding—before and after—the court hearing that affect mental commitment. More pervasively, the failure of society to care for its poor by adequate resources may force them onto the streets, depriving them of privacy, rest and adequate nutrition, and exposing them to imposition by others.[93] All of this has created an underclass in our society that lives on streets, in parks, on benches, over heating grates. Driven to distraction, perhaps already mentally unbalanced, they appear in mental commitment proceedings.[94]

The pathology of homelessness is not only social and economic, it is also psychological. Many of the homeless wander about, muttering to themselves, sometimes incoherent, sometimes incontinent, often out of contact with the world around them. In the cities, in the downtown business areas, "normal" people go to and from the office, to and from lunch, to and from shopping. We share the streets with the street people, but they are invisible to us.

Those who are homeless must redefine where a home is, converting the concept into a cardboard box, a space in a culvert or under a bridge, or a warm grate on a winter's evening. They are often cold, sick and hungry. It may be that mental illness or disease has led them to the streets, causing them to lose not only their homes, but their jobs and their families.[95]

They are often denied even the dignity of a place to wash or the clothing that would keep a body clean. It may be by a slow process of erosion or it may be in a quick explosion of

stripping away, but in the end, street people and the homeless are made to live in a world that they do not share and that denies them. They are made to feel crazy.

Travis Johnson appeared pursuant to a police officer's "hold." He sat at the opposite end of the long table and looked slowly and casually around the room, around the table, around the ceiling, and then over in my direction, seeming to make eye contact and yet, at the same time, seeming not to do so. As I spoke later with the two psychologists, we three reflected on the impression Mr. Johnson made. Dressed in dirty clothes, he was a compact man with a wiry build and a full shock of brown hair. During the hearing, his speech was never quite directly in response to the comments that prompted his replies. Often the speech was hurried, reflecting patterns that were preordained. He was good-looking, intense, yet somehow vacant. One of the psychologists said he reminded her of Dustin Hoffman in "Rainman," which the other psychologist confirmed, and I concurred that there had been more than a little bit of Robert DeNiro thrown in from "Cape Fear." This was not merely a game played to protect ourselves from boredom, at one end of the spectrum, or engagement, at the other. Rather, it was an attempt to approximate and capture a man of unusual intensity and potential for violence, who at the same time seemed possessed of intellect and intelligence, all under control and under the influence of medications.

Travis Johnson was a street person. The custody report, filled out by Officer Wilson, gave no address. On the line noted "address," the only entry was "transient." Mr. Johnson had been picked up, after physically resisting Officer Wilson, for having assaulted a "complete stranger under unusual circumstances." It developed in the precommitment investigation report, as well as during the testimony, that the "unusual circumstances" were that Mr. Johnson was standing in a 7-Eleven at the customer's counter and became impatient when he did not receive immediate service. Thereupon he slammed a dime onto the counter and turned around and

punched out the woman next to him. With that, he strolled casually out of the store and down the street. The police were called; the woman recovered and followed Mr. Johnson in her pick-up truck; the arrest was made.

At the hearing there was an assistant district attorney who had not previously appeared before me. He had received the file only minutes before. The investigating officer and the person who prepared the precommitment investigation report were not present. The district attorney offered the report and rested. I advised him, since he was new to me, that if that was the totality of his case, Mr. Johnson was going to walk out the door and possibly punch out other patrons of convenience stores around the metropolitan area. I suggested to him, since it was now 15 minutes past the time scheduled to start, that he might take a few minutes and locate his witnesses. He did so.

His report was that Steve Cole, who had prepared the pre-commitment report, would be arriving shortly. Officer Wilson was in a meeting and could not be disturbed. I told the district attorney to call the police station and to tell whoever was in contact with Officer Wilson that when he makes an arrest, he has to appear in court, and that the court insisted that he report immediately. This was done, and Officer Wilson ultimately appeared, having left his meeting.

Mr. Johnson had been taken to the police station, talking incoherently, following which he was taken to Portland Adventist Hospital. There he had given an identity, and a history that began in California, moved to British Columbia and Alaska, and then returned to Portland, Oregon. He lived on the streets, under bridges and in shelters. He had told Mr. Cole and Officer Wilson that he had monies available to him through Social Security, which he had last accessed through the welfare office in Hawaii. Mr. Cole testified that when he first spoke with Mr. Johnson, he seemed rather lucid, and Mr. Cole was inclined not to recommend commitment.

The second time, Mr. Johnson seemed to have deteriorated, and Mr. Cole's conclusion was that he would be at risk if he were returned to the population. Someone might take advantage of him. Officer Wilson confirmed this risk, not only describing the events leading up to his being called and taking Mr. Johnson into custody, but also testifying that it did not appear that Mr. Johnson had been able to connect with a shelter or an appropriate place to live or to survive in Portland, as evidenced by the grooves in the backs of his legs made by his raincoat as he walked endlessly and aimlessly on the streets.

As the testimony was developed, Mr. Johnson occasionally interrupted. During my explanation of his rights, at the beginning of the hearing, he had acknowledged several times that he understood what was being said, providing a kind of clarity that suggested he was in touch with the events around him. When I had asked him about medications, he had said that these were for his "lockjaw," so that he could speak clearly, which he felt he was doing at the hearing. In point of fact, his speech was slow, although coherent. His eyes wandered about the hearing room and occasionally settled upon mine, holding a direct and uninterrupted gaze directly into my face, across the length of the hearing table. He would hold that contact until I broke it.

What was most striking about Mr. Johnson—oddly enough, given the subsequent comparisons to DeNiro and Hoffman—was that he seemed unconcerned about the proceedings. He sat hearing testimony unfold that might lead to his commitment, yet he seemed detached and unaffected. This was exactly the way he had appeared after hitting the woman in the 7-Eleven store, for which he had indicated no regrets or feelings of guilt to either the police officer or the investigator. Yet although the lack of regret might lead to criminal charges, it should not be a basis for commitment, nor should a transient lifestyle. Indeed, the fact that Mr. Johnson apparently had survived as a transient for a number of years was

perhaps the best evidence of his ability to provide for his basic needs. If such a lifestyle constituted clear and convincing evidence to commit him, the implication might well be that a whole class of people, all living on the street and pursuing a transient way of life, might also be committed.

It seemed likely that Mr. Johnson was going to walk. At that point, however, his examination with the public defender began. As was usual, they had had little opportunity to meet and talk. The public defender therefore proposed to ask only a few questions. It would have been better if he had asked none. After two or three questions, the grounds for commitment began to emerge. To protect himself, Mr. Johnson said, he could and would carry a gun. The precommitment investigation report said that Mr. Johnson had told the hospital staff he was going to get a Uzi and come back and kill them. In response to the question of whether this was true or not, Mr. Johnson denied it. He did not own a Uzi. He did, however, have guns all around the neighborhood, all available to him. At this, the public defender blanched. He asked no more questions.

The two psychologists then questioned Mr. Johnson. His answers became more and more nonresponsive and convoluted. Many of them made no sense at all. He could not explain the store incident. He could not explain where his belongings, including a sleeping bag, might be located. He became somewhat hostile in talking about his style of life and where he had been sleeping and where he might stay in the future. He did describe having moved from California through British Columbia and back to Oregon, staying for a time on the coast. One of the psychologists had asked him at the beginning of her questions to remember three things; at the end, he was unable to do so.

In answer to my questions, Mr. Johnson was unable to tell me about his family. When asked about his parents, he answered in terms of his grandparents. When asked whether he had

brothers and sisters, he did not respond, although he did speak at some length about irrelevancies. The same was true concerning his education. When asked whether he had previously been hospitalized, he described the process to which he had just been subjected in oddly transitional yet appropriate language: people had checked him over to see if he was safe and then had taken him to the hospital and then released him. He did not bother them.

It was clear that Travis Johnson should be committed, yet in retrospect it is hard to say why. Until he struck the woman in the convenience store, he seemed to be surviving. While his mode of survival—living on the street, eating from garbage cans and staying in shelters or under bridges—would be consummate disaster for most of us, it is a conventional mode of life for thousands of Americans. For years Travis Johnson had been a success in his own community. His incoherence, his conventional failings, indeed, even his thought disorders had never been grounds for commitment in the past. It was only his striking of the store patron that brought him to the hospital and then into court. That may be grounds for criminal prosecution, but it is not grounds for commitment.

The streets of Portland, Oregon, like the streets of other major cities throughout the country, are occupied by transients, homeless people, drifters and others whose manner and appearance all mark them as appropriate for commitment,[96] or at least no less so than Travis Johnson. If Travis Johnson can be committed, then they may be as well. If the rest of the homeless are like Travis Johnson, then failing to commit all of them can only be attributed to haphazard filtering and screening or to a failure of resources and resolve. If all of the homeless could be committed, then we should refine and narrow our grounds of commitment and our system of screening people, since any nation that creates a class of homeless citizens and then commits them as mentally ill has convicted itself at least of heartlessness.

The case of a second homeless man, Tuttle James, is also worth discussing. He was a small man, bald, with a full Santa Claus-style beard. He sat at the opposite end of the conference table in the hearing room, looking about in a slow, deliberate, detached, and disinterested fashion. The medications sheet indicated that he had refused medication. He looked as though he was on lithium, but he was not. He was simply from another planet. On the front sheet of the precommitment investigation report, where home address is requested, was noted simply "homeless."

Although Tuttle James was 46 years of age on that day, he looked 66. His face had the tight, finely wrinkled appearance of a man who has gone beyond fatigue into a still-lower level of existence. His skin color was that of a man who has labored all summer in the sun, beginning with a Mediterranean background and adding exposure without sunblock, but Tuttle James had not been in the sun, since it was only spring in Oregon; although he had bathed at the hospital in the preceding days, his skin color was simply a product of dirt and destitution, hard to build up and hard to scrub down. His beard was the color of tobacco juice and amber. The tufted hair on either side of his scalp was spiked up toward the top of his head except in the back, where it curled over the collar of his sweatshirt. After settling in, he looked down, and the fine wrinkles around his eyes eased.

The notification of mental illness (physician hold) identified Tuttle James as a "transient." It related that the undersigned believed Tuttle James was "dangerous to him/herself or to some other person" and was "in need of emergency care and treatment for mental illness" because "patient is confused, unable to answer questions, worried, paranoid, and unable to tell where he is, where he lives. Appears psychotic."

The precommitment investigation confirmed this assessment. It reported that Mr. James stated that he had come to the hospital for "help with the voices." He stated that he had had

suicidal thoughts "because of all that has happened." Mr. James's cousin said Mr. James had been living on the streets the last few months, had become increasingly confused and suspicious, and had talked of suicide, adding that he might "take somebody with me." Mr. James had lost considerable weight and had given up on personal self-care. The report added that the cousin said Mr. James had used cocaine two or three years previously but not since. Mr. James had worked for a decade for the railroad and might be entitled to a pension, but that had not been pursued. At one point, prior to coming to court, Mr. James had been placed in four-point restraints. He expressed to the investigator a belief that he had been unfairly deprived of his freedom. He expressed suspicion toward the staff and the investigator, and acknowledged that he had heard voices, lived on the streets, and was uncertain where he ate.

In the hearing room, Tuttle James's appearance and manner were consistent with the report. When advised of his rights, he showed little interest in pursuing them. Although the public defender was sitting immediately to his left, Mr. James expressed no interest in having the public defender represent him. He observed that he could not have an attorney of his choice, which I confirmed. But, I added, the public defender was available. Since Mr. James did not seem to care, I asked the public defender to serve the court by assisting it in presenting Mr. James's case, if he had one.

There were two witnesses. The first was the investigator, Monty Pascoe. Essentially, he simply recited the contents of the precommitment investigation report. The second witness was Mr. James's cousin, Pete Deplace, who had known Mr. James for years. He testified that Mr. James had been living with his mother but during the previous eleven months had been on the streets and living under bridges. Mr. James had experienced a radical deterioration in his weight, in his personal appearance, and in his personal hygiene. Mr. James had said that he was contemplating suicide, although he had

taken no steps in that direction. As far as the witness knew, Mr. James consumed no drugs or alcohol. Occasionally Mr. James would call and ask for help, and Mr. Deplace would give him money, but beyond this Mr. Deplace could not provide help and did not know what to do for his cousin.

There was, as it happened, a third witness. Chuck Rack, a fourth-year medical student, appeared to testify. He had talked with Mr. James when Mr. James was taken to the hospital. Mr. James had refused medications and examination, so the medical student could tell the court very little. He confirmed that Mr. James's uncommunicativeness had been a feature of his presence at the hospital. Mr. James had said very little to anyone while there. Chuck Rack could not tell the court why Mr. James had been in four-point restraints.

That was the case for the state. The psychologists attempted to question Mr. James. They asked him the usual questions about where he was and what the date was and what his plans were. The responses were laconic, uninformative and begrudging. A similar response was directed toward my questions. Mr. James did not seem hostile or paranoid. Indeed, it seemed more that he viewed us and our questions as silly and naive, in view of the life he lives.

In an attempt to get him to open up, I asked a number of questions as to where Mr. James lived, where he ate, what he wore, what his plans were, where he would stay that night. To all of these I received short responses, often "I don't know." However, as the questions were being asked, Mr. James would make eye contact and sit erect, the corners of his eyes crinkling with a vague kind of amusement. It was as though Earthlings were asking a Martian about his flying saucer. Tuttle James was not so much homeless as simply from a different home.

The psychologists concluded that Mr. James suffered from a mental defect and was unable to provide for his basic needs.

I concurred and entered an order of commitment, despite the public defender's argument that it was not a crime to be homeless, nor was it a mental disease. I could agree with that. Yet the commitment would be appropriate because Mr. James was hearing voices and entertaining suicidal thoughts. As a result, Tuttle James was led away, with a somewhat bemused look upon his face.

He may simply have been reflecting upon the inadequacy of my legal analysis. The statutory standard requires clear and convincing evidence that a person has a mental defect before committing that person.[97] Mr. James might well have been thinking that there was precious little evidence of such a defect in the record. True, there was some testimony that he heard voices and entertained suicidal thoughts, but there was no evidence that the thoughts were far advanced beyond the thoughts any person entertains daily in his or her life. As to the voices, they were nowhere described in detail and might well have been a passing delusion.

The real concern was that Mr. James was wasting away. He had lost 30 pounds. The conclusion was that he could not care for his basic needs, yet really he had been doing exactly that. If he had lost 30 pounds, they were pounds he could afford to lose. If he did not have a place to sleep at night in a predictable fashion, it was at least clear that he would find some place and he would get sleep. His cousin testified that Mr. James did not like shelters or missions. One can hardly blame him. Those who prefer the privacy of their own home should not have a hard time understanding why Tuttle James might prefer the privacy of his own bridge. Moreover, while one might prefer the cuisine of a fine home or a fine restaurant, Tuttle James did not seem diseased or malnourished as he sat in the courtroom, although he could not say where he would eat his meal that evening if he were released.

Thus there may be a real question as to whether Tuttle James should have been committed at all. Actually, the more

troublesome question is whether committing Tuttle James necessarily means all homeless people can be and may be, perhaps should be, committed to mental health facilities.

Tuttle James was only representative of homeless people. Indeed, on any U.S. city street, at any time, it is possible to pass people who are muttering to themselves, uttering obscenities, who are dirty, underfed, poorly clothed, and scrounging a living at a bare subsistence level. They are not in shelters, because we are closing shelters.[98] They are not in mental hospitals, because we are closing mental hospitals.[99] They are not better clothed or better fed because we no longer provide, as a society, such services.[100] Many of them are far worse than Tuttle James; most are probably simply at his level of dysfunction.[101] They are there, at least in part, because society has made political choices as to how it should allocate its resources and services and institutions.[102]

The more interesting question, then, becomes why, with dozens of similar candidates on the streets of Portland, Oregon, and thousands on the streets of other cities throughout the country, was Tuttle James singled out? Ironically, the answer is that he had friends and family to care about him. His cousin arranged for him to be taken to a hospital, and the hospital arranged for him to be presented in court. If Tuttle James should ever read this, he might well ask, with friends like that, who needs enemies?

D. Screening out and screening in

Much of the literature concerning mental commitment focuses on the processes that *follow* a judicial hearing. Increasingly, my concern focused on the processes that *precede* a hearing. Every judicial process is, in a sense, the narrow neck of the funnel. In criminal court, defendants and cases are the end product of a broad funneling process that begins on the streets or in the homes and public places of a community, with events and people being filtered by police and complainants based upon events and acts that are observed and reported. Criteria are clear, and the processes

leading to arrest and presentment are fairly direct. However, as one moves toward processes in which prevention, deterrence, or security is less important and the rehabilitative imperative becomes dominant, the criteria and processes become greater and potentially more inclusive. Thus with juvenile court the longstanding criteria include such vague terms as "dependency," "neglect" and being a "child in need of supervision."[103]

The agencies that feed cases into the mental commitment process are at best a loosely connected network. They include state hospitals, state and local police, local hospitals and nursing homes, state and local social work agencies, private agencies and churches, families and friends. In all of this, in various settings, representatives of quite different disciplines are at work: psychiatrists, family medical practitioners, social work personnel, mental health professionals, case workers, clergy, lawyers, and, again, family and friends. Individually, such people may speak quite different languages in their professions and bring quite different motivations to their perspectives. Institutionally, depending upon politics, resources and personnel, the objectives of agencies and institutions may not only vary but be in collision. Unlike the policing that precedes criminal or juvenile court cases, there is no overall structure with respect to mental health. Nevertheless, all of the players may justify themselves as having the benign motive of "helping" a person "in need."

Significantly, at no hearings I conducted did any psychiatrist appear, although over half of the people subjected to commitment proceedings were the object of a notice of mental illness signed by a psychiatrist. Many of these same people were held in mental hospitals prior to their appearance in the hearing room, but no representative, physician or nurse appeared on behalf of those hospitals. Without the presence of such professionals, it is not possible in the course of a hearing or series of hearings to get an accurate picture of the processes and the institutions that are "upstream."

A concern for the processes in institutions preceding commitment is important because they have a powerful impact on the hearings. Not only do they largely determine which cases go to a hearing, but they also determine how the person will appear and function in the hearing room. A statement of the medications administered to the person while in custody accompanies the court file at the beginning of every hearing, but there is no comparable "victim impact statement" to describe the way in which the person has been affected by the simple fact of custody, restraint and brutal disruption in his/her life. If agency and institutional personnel do not appear in the courtroom, they cannot learn of the disposition of their cases, the values or rules employed, or the judicial expectations concerning them. Thus the vacuum between court and agency affects both—and the way they, in turn, deal with those citizens.

In a number of hearings I conducted, I was told that the investigator had "withdrawn" the notification of mental illness. As a consequence, there was nothing to hear. The person did not appear in the room. No witnesses testified. Perhaps the person was at liberty, perhaps not. I made a notation on the docket sheet, the single word "dismissed."

That single word encapsulates a great variety of outcomes, which may or may not be in the public interest. Somebody may have despaired of the value of the hearing and therefore agreed to involuntary hospitalization. Another person may have found treatment and in fact be well on the road to recovery. A third person may simply have returned to the home that produced the events leading to the petition for commitment. Yet another may have been treated outrageously and be a simmering volcano of anger. The possibilities are endless.

Thus a dismissal, while it has a benign cast to it, may be in fact an abandonment of responsibility by the court and by the state. At some point someone, doubtless several someone, caused a proceeding to be initiated. The essence of the

proceeding was that somebody was suffering from a mental defect, was unable to care for himself or herself, or was a danger to self or to others, yet now the proceeding and the person have simply disappeared. The concerns that brought them before the court linger.

Courts favor negotiation and settlement in civil cases, not only because they lighten court dockets but also because court remedies are usually less adequate than results parties agree to themselves. The same is to a considerable extent true in criminal court. Pleas of guilty are, in effect, a negotiated settlement between the state and the accused. But they are entered against a procedural backdrop that includes lawyers for both sides and the assurance of rights to the accused in an effort to effect parity of bargaining. The requirement of court oversight is a way of ensuring protection for the accused and for the public alike. In civil cases, any dismissal or withdrawal of a complaint after a responsive pleading may well require court approval.[104] Indeed, judicial sanctions may be imposed, although the case is withdrawn if it was wrongfully initiated.[105] Thus the question of whether a dismissal and a withdrawal should be allowed in mental commitment proceedings without anyone appearing on the record raises important issues in a range of such cases.

Consider the case of Yody Jann, a young woman of 23. According to the precommitment investigation she was suicidally depressed, planned to overdose on drugs, and was in confinement at a hospital. She had been seeing two physicians for counseling and medication and had slashed her wrists on a previous occasion. Ms. Jann had been hospitalized eight to ten times, including institutionalization at a state hospital, and for two years she had been at a clinic in Kansas. She was also subject to seizures. The precommitment investigation related that upon examination, Ms. Jann appeared oriented and had no hallucinations or delusions, but was simply "afraid of freedom." Based upon this assessment, the proceeding was initiated. Significantly, the report stated that the

investigator had not spoken with Ms. Jann's therapist. The finding that she was dangerous to herself was supported by all of the above plus a minor cigarette burn on her forearm.

Ms. Jann never appeared in court. The public defender appeared to say that she was agreeable to a "voluntary" commitment. The district attorney concurred. I was told that Ms. Jann very much did not want to appear before me. There was nothing personal in this, since neither by personal contact nor reputation did Ms. Jann have any basis for apprehension. Rather, I was told, it was simply that she did not want to appear in a courtroom. This would be stressful and frightening.

Court appearances are of course stressful, even for intact personalities. Yet no commitment is "voluntary." Moreover, at that time, the state hospital did not permit "voluntary" admissions. Ms. Jann would be entering that hospital with all of the limitations and restraints that would have been imposed had there been a fully contested hearing. However, there would have been no evidence or finding as to need.

Perhaps most important where the very issue is competence, a court must question the ability of a person to give effective consent. Perhaps we should respect the choices of people who are able to make rational choices, even to their seeming disadvantage. However, in a commitment proceeding, the existence of that ability is the central question at issue.

There is a public interest in a formal, open resolution of a commitment hearing. That interest is not necessarily served by an agreement—even a competent one—for hospitalization. It may be equally served by keeping the person in the community by involving family, friends and community resources. These possibilities are best explored in a hearing room in the presence of two psychological examiners who have not previously met the subject of the proceeding. By comparison, Yody Jann may well have made her "decision"

alone, in isolation, confronted by agency personnel who had made an inadequate investigation of her background, competence and possible resources for placement (if any was needed). Such a process presents the paradox of a young woman so suicidally depressed she could not appear in a courtroom, yet competent instead to choose a mental hospital.

After reflecting on Ms. Jann's case, I concluded that I would not again accept a commitment without a hearing, without an evidentiary basis, and without the person being present. This is the minimum basis on which a plea of guilty is accepted in a criminal case.[106] No less is due a person who may be committed to a mental hospital.

This approach is not necessarily well received. When the agency personnel and the attorneys are sure that a withdrawal of the proceeding is appropriate, they tend to view a hearing as a needless impediment. That same attitude may cause them to be superficial in their preparation, investigation, and resolution of cases. Two cases may illustrate these possibilities.

The hearing on Bob Kenny was delayed in beginning because the public defender told me this case would be a withdrawal and Mr. Kenny was going to go home. After waiting a few moments, I simply said to counsel and personnel that we were going to start, and I instructed the clerk to have Mr. Kenny brought into the courtroom. This decision was obviously not what counsel had contemplated. When Mr. Kenny appeared, I gave the usual advice concerning the nature of the hearing, the possible result, his rights, and the availability of counsel. I then said I understood that the parties had discussed withdrawing the proceeding and having Mr. Kenny go home. He corrected me, saying he would be going to a hospital for treatment. I asked him to tell me what his understanding of the arrangement was to be, and he explained that he would be required to go for treatment, to sign himself in, and to stay until he was well.

Mr. Kenny's appearance and affect were troubling that day. His eyes went off on a tangent with mine, his speech was slow, and his mannerisms were equally slow. He appeared to be intelligent, to understand where he was and what was going on, but everything seemed to be moving at three-quarter time. The statement of medications in Mr. Kenny's file indicated that he had been hospitalized over the weekend and had received medication as recently as Saturday, but not on Sunday or on Monday. The statement was signed and dated by a nurse and a physician as of Monday morning, the hearing date. I asked Mr. Kenny whether he had received medication that morning. He proceeded to describe what he referred to as "sleeping pills and lithium." Neither was noted on the hospital record. I asked him what he had received the preceding day, and he described similar medication. None of that was on the court's notification as to medication. Such medication, since it is directed toward mental illness and thus toward disrupting a person's normal pattern of behavior, has a profound impact on a person's ability to participate in the hearing. Such discrepancies were commonplace.

The principal investigator was called and testified. The report indicated that Mr. Kenny had previously been hospitalized and that he was a threat to himself and to his daughter. Beyond that, the report stated very little, partly because Mr. Kenny had refused to talk to the investigator and partly because this investigator usually said very little in his reports. As a consequence, all the court had to go on was the conclusory allegation, presumably based on undisclosed information, that Mr. Kenny had been a threat to himself and to his daughter. The latter was of particular concern. The investigator could not elaborate on this threat in his testimony. He said that on the morning of the hearing, Mr. Kenny had substantially improved. When the investigator had seen him previously, Mr. Kenny had been cooperative but had refused to speak. As far as the investigator knew, there were no hallucinations or delusions, and Mr. Kenny had never previously

exhibited any assaultive behavior. He lived at home with his wife and daughter and could go home again.

Mrs. Kenny was in the courtroom. She confirmed all of this information. She said that every few years Mr. Kenny had these episodes and needed treatment. I asked whether she was willing to have him come home, and she responded that she was. I asked whether he was a threat to her or to her daughter, and she said that he was not. I asked why that allegation appeared in the precommitment investigation, but she could not explain it.

Mr. Kenny also confirmed this information but nevertheless expressed a desire to stay in the hospital. I told him he was free to do so, but that this proceeding would be terminated. I refused to find that the notice of mental illness, the pleading by which the proceeding was started, was withdrawn. Rather, the entry was that it had been dismissed and that he was discharged. I added that I did not understand why the proceeding had been initiated in the first place. Moreover, it seemed to me that the misstatement of medications provided to the court had been dangerously misleading. I asked the district attorney and the investigator to convey this observation to the hospital.

The second case involved Lee Barry, a negotiated settlement at the other extreme. Whereas Mr. Kenny may have wanted to go to a state hospital but did not need to do so, Mr. Barry both wanted and needed such attention. Again, I insisted on probing a negotiated settlement.

Mr. Barry was brought into the hearing room, and within a few moments of sitting down he declared that he wanted to go back to the hospital. I explained the nature of the proceeding, the consequences, his rights of testimony and examination, and his right to an attorney. With Mr. Barry, as with a number of people, the advising of rights began to draw him out, and drawing him out became an effective method of

examination. It provided the basis not only for me but also for the psychological examiners to reach some conclusions about Mr. Barry. He had spoken with the public defender and he was agreeable to having the public defender serve him. He wanted to go voluntarily to the state hospital. I explained that there was no way to do so "voluntarily." If he were to go to the state hospital, it would be pursuant to a commitment, and he could be held there up to six months.[107] This was quite different from going "voluntarily." Mr. Barry responded fairly quickly and lucidly that he nevertheless wanted to go to the state hospital.

I asked why. Mr. Barry replied that recently he had been speaking too loudly and had been scaring people. I commented that he was not speaking too loudly this morning. I asked how he was scaring people. He said people *told* him that he was scaring them. Also, he felt that he was becoming mentally ill. He had noticed himself of late becoming loud and angry, and shouting at criminals in his apartment. I asked, What criminals? He said chiefly John Smith.

Mr. Barry stated that he had been a guard at a residential community and also at some of the clinics where he had been a patient. He found himself yelling at drug criminals. He had tried to kick the drug dealers out. By yelling at them, he attempted to help them "to get the mileage out of their systems." I asked if he had been successful. He said yes, he had managed to stop them and forced them to talk with him. He had asked them why they were always picking on him. Unfortunately, the administrators had let him go as a guard.

Mr. Barry went on to say that he felt as though he was becoming evil. He knew that he was getting angry. He felt as though he was bad and might hurt somebody. Upon questioning by the examiners, he said that he had never as yet hurt anybody, but he was afraid that he might. To them and to me, several times, he said he wanted to go back to the hospital. He had been there before and it had helped.

However, all of this testimony still lacked the grounds for commitment. The report itself, as noted, had been unrevealing. Mr. Barry's testimony was similarly insufficient. The statute required proof by clear and convincing evidence that Mr. Barry was a danger to himself or to others.[108] This was missing. It also required, as an alternative, that he be unable to care for himself and that supporting services in the community were missing.[109] This appeared not to be the situation. Finally, as a last resort, he might be committed as chronically mentally ill,[110] but Mr. Barry did not fit the statutory criteria. He clearly had a mental defect or deficiency, but it did not seem to meet the guidelines for commitment.

The precommitment investigator could add little to the picture. At that point I asked whether anyone else in the audience section was involved in Mr. Barry's case. His case manager, Ms. Zelnick, indicated that she was present and was available to testify. At that point the district attorney should have called her as a witness. Indeed, he should have spoken with her previously, but he had had no conference with her and thus had no inclination to call her as a witness. Instead, I called Ms. Zelnick as a witness for the court.

She testified that there was no place for Mr. Barry to go. He appeared to be threatening people, if not in fact threatening them with harm. Moreover, he had become worse over the preceding several weeks. She had worked with him for at least two years as a case manager with a mental health center. She could confirm such deterioration in his condition: he was unable to care for himself, and his condition involved not only what he himself had described but also hearing voices and seeing people in rooms when in fact there were no such people. With this additional information, the statutory criteria were met. The psychological examiners concurred.

The case involving Mr. Barry is a sharp contrast to the case involving Mr. Kenny. With Mr. Kenny, the agreement might have released a dangerous person into the community,

although it ultimately appeared that he was *not* dangerous, and there simply never should have been a proceeding. With Mr. Barry, the agreement might have committed the person when he was in fact not dangerous and could have remained in the community. Instead, commitment was required and appropriate. However, that conclusion was far from clear, and there was no certainty that either Mr. Barry or agency processes had made a rational choice for commitment. Such a result has serious consequences. For one thing, hospitals frequently perform badly.[111] A person inappropriately committed may be abused or neglected or—at a minimum—mislabeled and stigmatized.[112] Every commitment to a state hospital adds to the citizen's record of contacts with the mental health system. As the record builds, the likelihood of further contacts increases.

A court should be concerned not only for personal jurisdiction over people brought before it, but also for the personnel, processes, and institutions that capture people and present them to—or divert them from—court. If there is a population that is routinely or significantly restrained of its liberty in the small window of time between hospitalization and court presentment, failing to oversee withdrawal of petitions means those people never receive court oversight of their loss of liberty. Nevertheless they may be "churned" time and again.

The case of Lee Barry illustrates a continuing concern for the adequacy of the factual record on which commitments take place. The precommitment investigation was thin. It revealed very little concerning Mr. Barry's state of mind or his mental condition. It had been prepared by an investigator for the very agency that had been working with Mr. Barry for over two years, but the experience of the case manager from that agency was nowhere reflected in the precommitment investigation report. It was only by happenstance that the court learned that the case manager was in the courtroom, and only by departure from customary practice that she was called to

testify. The inadequacy of the investigation and of the report is perhaps best illustrated by the notation in the report that Mr. Barry had a medical condition in one of his legs that severely compromised his health; as a consequence, the report concluded, he was unable to care for himself and was a danger to himself. Yet Mr. Barry had walked with a normal rhythm into the courtroom; when he was asked, he said there was nothing wrong with his leg other than that he had broken it years ago and occasionally problems resulted, leading chiefly to a rash. The principal investigator, when asked about the leg problem, said that he had not examined the hospital records; that he had not spoken with the examining physician; and that he had understood from a doctor whom he named that the condition was potentially life-threatening. When asked who that doctor was, he said it was a psychiatrist on the staff of the mental health center. She had never examined Mr. Barry.

The negotiated settlement system tends to screen out people whose cases should by all normal considerations be reviewed in court, on the record, before those people are committed. The very label "voluntary" in such cases requires scrutiny. Many cases, of course, are screened away without a petition or a proceeding simply because there are no grounds for a proceeding and there is no disposition. That is quite proper, and there is no suggestion to the contrary here. But many cases that should never have been brought nevertheless proceed to a commitment hearing. In such cases, agency processes may simply have failed, or, occasionally, the proceeding goes forward simply because the law—or our societal values—is unclear. The case of Cassie Stone illustrates the former; the case of Roberta Dennis illustrates the latter.

Cassie Stone, a thin lady in her mid-seventies, appeared in response to a police hold and a hospital commitment that had held her in custody over the weekend. She sat quietly, with dignity, at the far end of the conference table, around which the various court personnel were arrayed. As the advice con-

cerning the proceeding and rights was delivered, Ms. Stone interrupted to ask why she was there. I responded that the notice of mental illness and the nature of the proceeding were such that she might be found mentally ill and ordered to commitment in the mental hospital. She responded quietly, trembling, that she had never been mentally ill a day in her life and that she wanted to know what the court was going to do about the police who had broken into her home. With this, I turned to the assistant district attorney.

After the assistant district attorney, who had received the file only a half hour earlier, had made his statement, I went directly to the principal investigator. Essentially, Cassie Stone had been living in her home for nearly 30 years. It was in a lower-middle-income part of the city, which had been slowly deteriorating. Her sister had become concerned about Ms. Stone's ability to care for the yard and the interior of the home and to buy food for herself. Several times the sister had visited the home and been dissatisfied. During the previous week or two, according to the principal investigator, the sister had been unable to get into the home to talk with Ms. Stone.

That was it. There was no other testimony from psychiatrists, family, or agency personnel. I asked the principal investigator about the earlier reference to police breaking into Ms. Stone's home. The investigator had nothing to say.

I then turned to Ms. Stone. She had been at home when a knock had come at the door. Moving slowly, she had been unable to get to the door before it was broken open. Three police, or sheriff's deputies, came in, and, without giving her time to change her clothing, they removed her. When she persisted in struggling and, as she said, screaming, they took her to the hospital. She had been kept there until her appearance in the courtroom. She added proudly that she had refused medications.

activities at home and at work, but without pleasure or enjoyment. They went on to say that they loved her and wanted to help in any way they could. Specifically, the father-in-law said that he was willing—along with his wife—to have Roberta Dennis come and stay in their home. He would remove from the home his hunting weapons and any other items that could be used for self-destruction.

With this, I turned to Roberta Dennis, having listened to her at length, and said that it seemed to me she posed a difficult problem. The evidence was clear that she was a competent and effective person who wanted to kill herself. Unlike other cases, where people who had appeared in commitment proceedings had made failed attempts at suicide, it appeared that she was quite capable of carrying out her intent—and yet to do so would be, it seemed to me, a terrible tragedy. What was it that she proposed should be done?

Roberta Dennis obviously posed a difficult philosophical problem. There may well be a right to terminate one's own life. Certainly there is a right to refuse medical treatment when one's life is in danger. Moreover, although committing suicide may be a crime, it is not—at least under the statutes[113] —grounds for commitment unless it is a product of mental illness or disease. The statute provides no grounds for holding that a desire to commit suicide is by itself a mental disease or illness.

Roberta Dennis responded that she thought she could be trusted not to kill herself because the involuntary custody over the weekend had forced her to see the path she was traveling. She had become angry not with the hospital, but with herself. She now wanted to know why there was no joy in her life, and why she wanted to destroy herself. It seemed, as she watched other people enjoying life and having fun, terribly unfair. She had always rejected the possibility of counseling but now would seek it.

With that, the in-laws and the principal investigator undertook to represent that psychiatric counseling would be available through an area agency on mental health. Roberta Dennis promised to stay with her father-in-law and to keep her first appointment on Thursday. No option for probation was available, so the decision was one of discharge.

The psychological examiners, having brought out a good deal of the information just summarized, were interested in Roberta Dennis's plans. Would she go through therapy? Would she sign an "anti-harm" contract with the therapist? Would she follow medical advice? To all of these questions she answered that she would try, but she actually did not know. She had never cared for herself, she said. She had never talked with people about herself. The examiners wanted to know, then, how she would be safe. How, if the depression were to return, would she keep from becoming suicidal? Ms. Dennis responded that she thought talking with someone would help stave off the depression. If it came back, she would talk with her husband's family. She would even talk with her husband. She could only wish that she might be able to talk with her own family.

There may be lives that are not worth living. Someone who is paralyzed from the neck down has a life. A prisoner in a concentration camp, subject to continuous abuse, has a life of sorts. A schizophrenic, whose mind and being are occupied by forces or personalities continuously talking to him and demeaning him, also has a life in some sense. Roberta Dennis's life, however, was different from these. It was a functioning life but totally devoid of joy, pleasure, reward, meaning. It was the life of a person who was bright, attractive, accomplished, and effective, yet who felt none of that and derived no pleasure or reward from it. Would it be rational for such a person to end such a life? Should society permit it?

Partly the answer turns upon what might yet be made of such a life. Could Roberta Dennis, through therapy, counseling, self-help, and support from others, change not her life, but her enjoyment of it? Indeed, can one draw a distinction between one's life and one's enjoyment of it? The psychological examiners seemed to think, and Roberta Dennis was intent upon pursuing this, that she would be able to come to an understanding as to why her life gave her no meaning. She was sufficiently angry at her confinement and sufficiently upset about why her life lacked meaning that she seemed intent upon finding out why. From this understanding might come the potential for meaning and for having a life worth living.

As a consequence, Roberta Dennis was discharged. There was no commitment. There seemed to be no mental illness or imminent danger to self, unless contemplating suicide is by itself sufficient evidence of mental illness to justify loss of liberty. The interest of the state was conceded, that the state had a stake in helping Roberta Dennis to save her life and to make something of it. Yet that concession may well be in doubt. If Roberta Dennis had sat in the courtroom and presented quite a different proposition, then difficult issues would have been posed. Let us suppose that Roberta Dennis had said, here am I, intelligent, effective, rational, living a life not worth living and convinced that it will never get better. Suppose that she had said Get out of my way, I want to get out of my life. If society is convinced that she is wrong, may it interfere? If society is convinced that in fact Roberta Dennis could acquire, assume, or come into a life that would give her joy, may society coerce her into such a life? Perhaps the answer turns partly upon the methods that society would use to achieve its desired results: drug therapy, electroconvulsive therapy, enbindment, restriction of liberty. Even passing all of that, however, may society appropriately interfere with the Roberta Dennises of this world, who lead lives of quiet desperation?

Cassie Stone and Roberta Dennis are instances of a pattern of referral to court where grounds are dubious at best. Perhaps the chief criticism should be that the process of bringing people before the court is often preceded by physical force and custody. In such cases, arrest and seizure hardly seem necessary. The only justification—as with the street people discussed earlier—must lie in agency discomfort or fear of liability if swift, dramatic action is not taken. However, such action may be far more traumatic and destructive than the forces that—it is believed—are placing lives in jeopardy.

At least that was the conclusion of Cassie Stone and of Roberta Dennis. They left the courtroom discharged and free, but forever shaken and changed by the imposition of force on their lives.

III. Reflections, comparisons and observations

A. An intermediate assessment

The Oregon processes of mental commitment are largely in the hands of mental health agencies, and these are largely beyond the control of—indeed, unknown to—the judges who conduct the hearings. Left unattended, the agencies play a powerful role in the lives of people who come their way. To a considerable extent the liberty of citizens may depend on their accommodations to the asserted needs of agencies. A case may illustrate this.

Peter Nickel appeared on a petition to revoke conditional release. He had been the subject of a mental commitment proceeding two months before. Mr. Nickel was a young man of 22, neatly and casually dressed, a bit overweight and a bit uncomfortable as he sat at the beginning of the hearing. He had little difficulty following the explanation of the proceedings and of his rights. The public defender made a presentation to the effect that Mr. Nickel had not violated the conditions of release, in fact had genuinely tried to comply with them, but simply could not get treatment from the

regional mental health center. She said that Mr. Nickel's mother was in the hearing room and was prepared to confirm this information. The district attorney simply represented that the opposite was true and that the investigator was prepared to proceed, whereupon he was called and essentially offered his report into evidence.

That report said that Mr. Nickel had not kept appointments; had refused to follow physician prescriptions as to medication; had left home without permission; and was out of control. As a result, Mr. Cooper testified, it was necessary to apply for a warrant of arrest, since obviously the respondent was "hostile to the process." Mr. Nickel had been arrested and held overnight to appear. During this brief presentation, Mr. Nickel became upset. He interrupted and essentially denied the substance, if not the entire contents, of Mr. Cooper's presentation.

The public defender then called Mr. Nickel's mother, who had spoken once or twice from the audience section during Mr. Cooper's presentation. She testified that Mr. Nickel was living with her, as required by the conditions of release. He had had difficulty "hooking up" with the mental health clinic. The public defender had called the clinic and had been told by the clinic, according to the mother, that they did not have to treat her son. The court could tell her son what to do, but it could not tell the clinic. The clinic did, however, ultimately place Mr. Nickel on medications that caused a severe rash and nausea. As a result he could not hold down food and therefore stopped taking the medication. Instead, he had private physicians arrange for appropriate medication, which he was now taking.

The mother did testify that Mr. Nickel had left her home three times after release. Six weeks before the hearing, he would became "restless" and go out at 1:00 or 2:00 A.M. for a walk. Since they had moved to a new setting, however, he had not engaged in unauthorized night walking. He had, according to

his mother, attempted to go to appointments. The principal problem was that he had not been given any. Essentially, the position of the regional mental health center had been that Mr. Nickel did not need treatment and that the center did not need to give treatment if it was not required. Mr. Nickel's mother was clear that, in her judgment, her son had stayed in compliance with the conditions of the release, or at least had made sincere efforts to comply.

Mr. Cooper did not effectively counter or contradict this testimony. Once again, the quality and scope of the evidence severely hampered decision making. If in fact Mr. Nickel had failed to keep appointments, nobody from the regional mental health center was present to establish that fact. No appointment logs were introduced into evidence. If in fact nobody from the mental health center was willing to treat Mr. Nickel because they had concluded treatment was inappropriate, nobody appeared to testify. Why anyone should continue to care about his three night-walking episodes was not developed on the record. The principal issue in the Nickel case therefore became not what to do with Peter Nickel, but why the proceeding had been initiated at all. Indeed, in reviewing the file and listening to the testimony, I thought it was a fair question as to why he had been committed initially. An appeal, I noted, was pending in the file.

What was happening was quite clear and quite ominous. *Because* Nickel *had* been committed, the agencies "downstream" in the process had to deal with him as though treatment was appropriate for him. There are two kinds of agencies. One actually delivers treatment. That kind of agency rejected Nickel. The second kind of agency monitors and tracks people who have been committed. That agency noted that Nickel was not getting treatment as required. It therefore found him out of compliance with the terms of the conditional release. Rather than inquiring why this was so or applying for a modification of the terms of the release, the agency stopped at the fact of noncompliance. It was enough

to know that the system was not working; Nickel must therefore be committed.

I inquired of counsel as to whether I had the authority to reconsider and reopen the earlier order of commitment. They were unanimous that such authority was lacking. Next I inquired of counsel as to whether I had the authority to modify the conditions of release. They thought I did. They also thought, although they were in some disagreement about this, that I might have the authority to determine that the conditional release had been satisfied and therefore to discharge Mr. Nickel. That did not seem wise, but modifying the terms of the conditional release did. Therefore I modified the six or seven terms to provide that if he should be found in violation again, Mr. Nickel was not to be arrested but was simply to be notified of the hearing and given an opportunity to attend. Moreover, the taking of medication would not be made a condition of release. Mr. Nickel expressed his appreciation for the opportunity to continue at liberty, although he declared emphatically that the arrest in the early morning hours had been totally unnecessary and most disruptive.

In the Nickel case, two different bureaucratic processes were at work. One was the necessity of cubbyholing people. Mr. Nickel simply did not fit: he had been committed, but he should not have been committed. Thus there was no appropriate category. The other process at work was the bureaucracy's reaction to anyone who is hostile. Essentially Mr. Nickel was a functioning person and insistent that he be treated as such. He knew that he was being wronged and that the agencies were in the wrong. He insisted, in what was characterized as a hostile way, that he need not cooperate with a wrong-headed process. Unfortunately, noncooperation can be taken as evidence, indeed often *is* taken as evidence, of mental incompetence.

The Nickel case in a nondramatic way, illustrates the reasons why this article has been written, the way it has been written, and the intended audience. For some, this article will afford the first detailed description of the people and the processes to be found in a courtroom conducting mental commitment hearings. Since in the main those hearings are private or are poorly attended, opening such a window may have value for basic public information or, it may be hoped, beyond that to public scrutiny and reform. Also, perhaps the portrayals will be of use to students and professionals. Offering, as this article does, the added perspective of a judge is a valuable and rarely available approach. Judges have written about their work in the past, but usually at the appellate level and in the abstract. An attempt at a case-by-case review, shedding light on the decision-making process, may—it is hoped—add to the literature on the judicial process in important ways.

It may perhaps have been unnecessary to add the kind of details included in the preceding case descriptions. Whether someone waved her hand, whether someone thought he was the king of Ethiopia, whether family members were present in a courtroom, or whether the police broke down the door of an old woman, all of these may seem irrelevant points. However, they seem important to the author. In the fields of law, ethics, and medicine there is a rich tradition of teaching by the case method. Such teaching requires, in hospitals and medical schools at least, the actual presentation of patients and their participation in the discussion of their cases. In the tradition of the law, the "case method" taps a similar vein, although at a somewhat higher level of abstraction and in a somewhat more didactic way. To put the matter somewhat differently, a mosaic of many parts depends upon detail to test the thesis of the designer and the reaction of the viewer.

Still, the author sought to eliminate unnecessary detail. The dates of the cases are omitted, and the names of all the participants have been changed. The names of certain locations have also been changed. Although much of the material

involved is a matter of public record, it remains true that official intrusion into the lives of the respondents in these cases has already worked a significant invasion of autonomy and privacy. The author sees no need to add to that invasion, particularly since his perspective was uniquely that of decision maker and posed the possibility of additional imposition upon the respondents. Consistent with the statutes of Oregon and the Code of Judicial Responsibility, the preceding cases could summarize the observations and knowledge of the author without needlessly intruding upon the lives and professional roles of the participants in the hearings.

Certain questions should arise in the mind of the reader concerning the preceding text. First, while the observations are accurately reflected as those of the judge during the proceedings, it may be wondered whether that perspective itself is so idiosyncratic as to be of limited value. As a double check, I asked students from time to time to sit and observe cases. Following that, we discussed my impressions and compared them with theirs. The preceding discussion reflects that process of verification and confirmation. Second, it may also be wondered whether the processes reported in the preceding material were unique to my courtroom. With that in mind, I also requested students to observe hearings conducted by other judges in other courtrooms and other counties. The comparisons were useful, and by and large the observations made earlier would apply to other courts as well. Personalities and, to some extent, procedures vary, but the idiosyncrasies that might pertain to any particular courtroom or judge have been excluded from this article as much as possible.

It may be worthwhile noting at this juncture that as my service with the mental commitment process continued, there were meetings with other judges. Some of the points made in this article were raised and were either confirmed or rejected by others. It did appear that the author spent approximately twice as much time on each case as other judges and, to good

or to bad ends, was much more active in his questioning. It also appeared that my practice of taking the initiative in directing the proceedings was not a practice others shared. Without developing this discussion further, it seems fair to say that these departures were a source of concern and criticism.

Perhaps most important, the question should arise as to what happened to the people who appeared in the cases described earlier. The very nature of the proceeding in Oregon isolates the judge, so that he or she has little control over the processes bringing in (or excluding) people and little knowledge of what follows. Most of the commitments, if not all, are to the Department of Mental Health, and people then travel to Dammasch State Hospital (now being closed). What happens to them there and how long they stay and what happens subsequently is unknown to the court and beyond its control. More difficult—and potentially more important—a judge has no way of knowing what happened to those *not* committed. Did they survive? Thrive? Fail? Hurt themselves or others? In Oregon, at least, judges are largely in the dark.

Whether this is a significant shortcoming or not is not self-evident. It would seem to the author that it is. Equally unclear is whether anything can be done about it; again, to the author it would seem an extension of the court's cognizance would be an obvious answer. However, the success of such an extension, in an era of limited agency and judicial resources, is far from clear. With that in mind, the author undertook to observe mental commitment hearings in a system where the judge—unlike Oregon judges—deals extensively and intimately with the terms and conditions of commitment and treatment. That is the subject of the next portion of this article.

At this point some tentative conclusions may be possible. First, the failing in Oregon to deal with the place and terms of disposition seems significant and represents such a sharp

departure from customary judicial process that it should be remedied. In any other area of judicial process, judges are very much involved with relief and disposition. This is certainly true in criminal cases. It is true as well in civil cases seeking damages or injunctions. It cannot be said that mental health dispositions require such specialized expertise that the subject matter is beyond capability of judges. Indeed, the presence of psychologists in the hearing rooms in Oregon is testimony to the contrary.

Second, it would seem that the Oregon courts need better information and perhaps enhanced control concerning the processes that bring people to them for mental commitment. The analogy to criminal courts is instructive. Judges do not administer policing agencies, but through the exclusionary rule they routinely review the work of the police. Moreover, police regularly testify in court and thereby can report to their employers a court's action upon the work of the police. In Oregon, in the mental health context, representatives of hospitals rarely appear. Perhaps most important, the mental health professionals who send people to the courts, or later treat them, do not appear and testify and do not have regular communication with the courts. Thus a discontinuity and an irresponsibility are built into the system.

Third, the place or status of the judicial function of mental commitment within the overall judicial structure is deficient. There is a hierarchy of values in a courthouse, as in any other specialized organization. It is regularly recognized, for example, that juvenile court work and family law work carry the least prestige. It is also often observed that they therefore attract lesser resources. The same appear to be true of the mental commitment process. At the risk of offending specific individuals, the mental commitment hearings, procedures, and personnel must be the subject of methodical and deliberate upgrading in order to ensure adequate resources and personnel for the protection of citizens coming before the court.

At a minimum, the processes and symbols usually associated with court procedures should be ensured in mental commitment proceedings. The hearing room in which mental commitments are conducted in Oregon would not be recognized in any conventional sense as a "courtroom." There is no bench, no bar, no tables for counsel—and no sense of coming to a special place where justice is respected and dispensed. Courts are special and important, and people look to them for protection. People need to know, when they come into the courtroom, that they have come to a safe place. It is equally important to remind agency personnel—and, for that matter, judicial personnel—that this is true.

Having reached these tentative conclusions, I decided it would be worthwhile to observe the processes in another jurisdiction. In particular, it seemed important to do so in a jurisdiction where the judges are directly and extensively involved in the disposition and treatment of people who are committed. Substantively, that seems the major deficiency of the Oregon procedure. In Maine, by contrast, the judiciary is extensively involved with agency personnel in determining the content of what happens after a commitment.

The next section of this article therefore deals with the process as it unfolds in the state of Maine.

B. A point of comparison: the State of Maine

Every state commits mentally ill persons to treatment facilities or agencies, but not every state does this in the same way, pursuant to the same criteria or with the same kinds of agencies and treatment programs. Studying other states is thus worthwhile, since it provides an opportunity to test and compare explicit choices. Equally important, and perhaps more so, actual observation of the processes in other states, coupled with interviews of the people involved, would develop the *implicit* unspoken choices that are made. These may be as important as the choices made consciously.

For example, when I discussed Oregon procedures with a long-experienced family court judge from Hawaii, he asked whether mental commitment proceedings in Oregon are conducted in the courthouse or at the state institution. In response to learning that they were at the courthouse, he reacted positively, but he reacted negatively to learning that the commitment proceedings were in a hearing room, not a conventional courtroom. He also reacted strongly when he learned that none of the judges wore robes. All of the courtroom symbols are important to the meaning and substance of justice. When I asked whom the meaning is for—the respondent, the lawyers, or himself—the reply was that the meaning is most important for the agency and institutional representatives, particularly physicians, to impress them with the authority and importance of the legal system in screening the work of mental health agencies.

The presiding judge of the District Court of the State of Maine arranged to introduce me to Judge Courtland Perry, who had conducted mental commitment hearings at the Augusta Mental Health Institute (AMHI) in Maine. I met with Judge Perry and explained my scholarly and academic interests, my experience as a part-time judge conducting hearings on mental commitments, and my interest in observing another judge in another system. It seems clear that there are differences from court to court and state to state and that these differences were worth exploring. I was particularly delighted to have the opportunity to observe Judge Perry, since he was the prime author of the Maine mental commitment statute,[114] which varies in significant ways from the Oregon statutory provisions. In late spring, at 8:00 A.M on a Monday morning, Judge Perry and I met in Augusta, talked for approximately a half hour, and then drove to the Augusta Mental Health Institute to conduct court business.

Contrasts to Oregon proceedings were immediately apparent. Proceedings in Maine are "private," not open to the public.[115] They are conducted at the mental hospital in either Augusta

or Bangor. The hearing room at the mental hospital was approximately 15 feet wide by 30 feet long, cinder block on one side, institutional tile on the other, with ample window space and lighting and a rainbow stripe diagonally from ceiling to floor in the middle of the wall that faced the windows. There were four rows of four chairs each in the audience section facing toward a table with three chairs and two microphones for the attorneys and, in front of that, another table with two microphones for the judge, behind whom sat a court reporter with a tape-recording machine. The table for the lawyers was a metal-legged, formica-type folding table approximately 10 feet long, the table for the judge was institutional-style oak. At the end of that table was a chair for a witness. Anyone coming into the room would have understood that it was not set for a conference, for teaching, or for a public meeting. It would have been apparent that it was set as a hearing room, to take evidence and to make decisions. However, it would not be apparent that this was a *court* as opposed to an administrative agency.[116]

Psychological evaluations are available to the judge, as they are in Oregon, but in Maine the reports are prepared in advance.[117] In Oregon the only reports are those of a mental health investigator, essentially providing background on the case; the psychologists' evaluations of the respondent are done during the hearing, on the fly, with the report consisting of a single sheet hurriedly prepared during the hearing itself. In Maine the psychologists visit the patient once or twice, talk with hospital staff and medical personnel, possibly confer with family members, and then give a report.[118] The reports are part of the hearing record without having to be introduced as exhibits. Thus on Monday, Judge Perry knew in advance what the psychologists' views were on the grounds for commitment, the appropriateness of disposition, and the length of time of institutionalization.

At a hearing on a case, then, there may be no witnesses on any of the elements the psychologists covered.[119] If so, the

only testimony would come from the treating institution, presenting a treatment plan.[120] The respondent himself or herself might testify, in opposition.[121] Occasionally a defense expert might be called.[122] But the substantive grounds are not reviewed, generally speaking, since it would be a repetitive exercise.[123] Instead, the attorneys stipulate in lieu of the oral testimony of the examiners. This, of course, is the reverse of the procedure in Oregon.

When the examiners agree that there are no grounds for commitment or there is no need for treatment, the judge knows this in advance.[124] The petition for commitment will be withdrawn.[125] In fact, that happened with two of the cases scheduled for my first day of observation. A third case was dismissed that morning, again, I was told, because the staff felt they could not bear their burden. One other case led to a voluntary commitment,[126] again a contrast to Oregon, where voluntary admissions are not available to the state hospitals. Judge Perry commented later that the absence of such an option would place inappropriate pressures on the judicial processes.

In Maine, it is the "hospital" that is presenting the case for commitment.[127] In Oregon, by contrast, the case goes forward by the district attorney, who is, as noted earlier, often unfamiliar with the case. The Maine hospital has an attorney present, but it undertakes itself the burden of assembling the case for commitment, including a treatment plan, and proceeding with it.[128] In Judge Perry's view, this meant greater coherence and force in meeting the burden of proof. All of this procedure is largely enhanced when the patient testifies, confirming the grounds of commitment and the need for treatment. In the cases that go forward, the patients often testify, as in Oregon. The Maine docket typically had five or six cases. I noted that this would have been an unusually heavy docket in Oregon. Judge Perry commented that this was an average docket, although some five to ten years earlier a docket might have had ten or more cases, while within the

past year or two the number of cases had dropped to an average of two or three a day, once a week. Recently the number had increased, for unknown reasons.

I suggested that a policy decision might be being made by the state mental hospital. In Oregon, patients are presented from area mental health agencies, from three or four different hospitals, from the state mental hospital, and from the policing agencies (via one of the other institutions or agencies just noted). In Maine, the patients are presented from only *one* source, the mental health institutes. Thus Judge Perry's docket is at the mercy of whatever policies, criteria, or shifts are undertaken at the mental hospital. This means that a single set of criteria, imposed by a single agency, would govern the intake of the commitment process and that internal institutional changes could affect the court's functioning. In Oregon, that process is subject to the views and vicissitudes of six more agencies and institutions. The internal agency choices are splintered and largely invisible.

The only case remaining on our first Monday was that of a Ms. Harding, whose case had first been heard two weeks earlier. Judge Perry had rejected the treatment plan prepared by AMHI and ordered them to develop another treatment plan. Later we discussed the fact that those options would have been beyond my authority in Oregon, where the commitment is simply to the Department of Mental Health, which has total discretion to develop a treatment plan and its location and timing. In Maine the judge can accept or reject a plan, although he cannot specify modalities of treatment.

The attorney for Ms. Harding had been carried forward from the preceding two weeks. The system was to appoint an attorney to handle a morning's docket. There was no public defender system in the Augusta area, which is relatively rural. Both Ms. Harding's attorney and that morning's attorney were on a list of volunteers called in rotation to serve as defense counsel. Although the pay was small, they did the

work because it was a matter of satisfaction and challenge for them. That morning, Ms. Harding's attorney was appearing again to challenge the treatment plan, now revised, to be offered by AMHI. He had been notified a week in advance of the cases on which he would be appearing, and he had received the psychologists' reports (or, in this case, the treatment plan) on the Monday preceding the hearing day.

Two witnesses appeared for the hospital, a Ms. Montrose and a Dr. Mary Goetz. Ms. Montrose presented the revised treatment plan. It was, she said, significantly different from the earlier plan in many respects. First, they had instituted several types of therapy, not just one-on-one counseling with a psychologist once a week. Several of the staff would be available for Ms. Harding, including two psychologists and two psychiatrists, along with a social worker and a mental health worker. Second, the psychologists would meet with Ms. Harding at least one hour a day. Third, an administrative hearing had been applied for concerning the change in medication, dropping Prozac and using another form of medication for which there might be intravenous "backup," so that compulsory medication could be undertaken. Ms. Montrose said there would be another hearing before electroconvulsive therapy (ECT) was undertaken; ECT was not *now* a component of the treatment plan. Finally, the attending physician had been changed, since the doctor who had been serving in that capacity had been sick for eight weeks.

Dr. Goetz is a licensed psychologist; Ms. Montrose is a master's level social worker. Both are on the staff of AMHI. Dr. Goetz testified that she had not drafted the plan just outlined by Ms. Montrose. She was, however, impressed by it. It did respond to the four or five issues that the judge had raised two weeks earlier; in addition, Dr. Goetz mentioned that there had been progress in determining whether the charge in the death of Ms. Harding's child would be presented to the Grand Jury. This was the first mention of a death in the family. The proposal was exceptional in terms of

the resources being committed. At least four months would be required, in Dr. Goetz's opinion, to see whether the shift in medication would work.

The defense's cross-examination of the first witness was calculated to show that these changes were actually afterthoughts. Moreover, with limited resources, it was unlikely that any of them would actually be implemented. Mr. Gaudin also made the point that Ms. Harding had made more progress when she was in a different unit prior to the one where she now found herself and would be retained under the modified treatment plan. He made the same point through the only defense witness, Dr. Wells, a psychologist. Dr. Wells sat in the witness chair, a man in his mid-forties, heavy of build, with a gray beard and a tiny long, wrapped pigtail hanging down his back. As to the plan, he testified that he was "terribly ambivalent." The medications could not work if Ms. Harding was "situationally depressed." The counseling was "old wine in new bottles." They couldn't even tell what was wrong with her, since essentially she had not communicated since her arrival in August, following the death of her child. The principal psychologist was a wonderful man, but since he had lost his voice due to his illness, the half hour to hour meetings would have to be conducted by his passing notes back and forth, which Dr. Wells opined might be the "innovative" therapy that the new treatment plan contemplated. He did not belittle the plan so much as he accurately appraised the task: Ms. Harding was a "candidate for the passive/aggressive Hall of Fame." She was one of the most difficult patients he had ever seen, and outside expertise was required, but the treatment plan offered none.

The attorneys for both sides closed by essentially agreeing that the new plan had a number of ambitious, innovative elements. Defense counsel urged that it be limited to two months, to see if the new medication was working. The judge imposed a three-month term, to be reviewed by the court, since that would be necessary to allow for the admin-

istrative hearing to authorize the medication, followed by at least two months to see if it worked. In the back of the hearing room, Ms. Montrose and Dr. Goetz heaved a huge sigh of relief, then hugged each other. In turn, they were congratulated by Dr. Wells. It was clear that the judge had forced a major rethinking by the institution and a reallocation of its resources, and that the hospital had taken the judge most seriously.

The court in Maine, by statute, must find by clear and convincing evidence that a person suffers from a mental illness and is experiencing a likelihood of serious harm to self or others before entering an order of commitment.[129] In addition, however, the court must also find that involuntary hospitalization is the best available means for treatment and provides the least restrictive treatment setting and modality.[130] Moreover, the court must be satisfied with the treatment plan submitted by the applicant.[131] This means a treatment plan must be presented to the court.

The result—as the Harding case illustrates—is to change the dynamic of the hearing. The proponents of commitment are no longer simply those who have previously dealt with the respondent and are now trying to get rid of him or her. Rather, they become the people who will have to deal with the respondent in the future and are seeking commitment to effect that result. The committing judge thus has expanded oversight and resources available for decision making.

The Maine statute specifically provides, as noted, that in addition to proving the respondent is mentally ill, the applicant must show that "after full consideration of less restrictive treatment settings and modalities, inpatient hospitalization is the best available means for the treatment of the person."[132] In addition, the applicant must submit testimony "indicating the individual treatment plan to be followed by the hospital staff, if the person is committed. . . ."[133] If the court finds that the person is mentally ill, that inpatient hospitalization is the best

available means of treatment, and that "it is satisfied with the individual treatment plan," it may then order commitment.[134] If the court is not satisfied, the statute provides that the court may continue the case for no longer than ten days, "pending reconsideration and resubmission of an individual treatment plan by the hospital."[135] There is no provision for what the court should do if it remains dissatisfied *after* resubmission. Clearly, it may not commit.[136] Less clearly, but equally compelling, it should not discharge someone who clearly needs appropriate treatment but for whom an appropriate treatment plan has not yet been submitted. The court in Ms. Harding's case pursued the necessary but difficult path, ordering the necessary additions to the treatment plan, thus making commitment possible.

The extent to which the court in Maine is involved with the treatment process and review of treatment plans was further evidenced by two subsequent cases. Nathan Blank had spent, off and on, nearly 30 years at AMHI. Carolyn LeBlanc was in her early twenties and had been at AMHI for nearly six months. In her case, as it developed, she was in custody at the mental hospital awaiting a decision by the attorney general as to whether she would be criminally charged in the death of her child. Neither Mr. Blank nor Ms. LeBlanc appeared at their hearings, although each was represented by counsel, who stated to the court that the client was choosing not to appear or participate personally. The court accepted those representations without further inquiry of the respondents themselves, as it had in Ms. Harding's case.

In both cases the court inquired as to whether the attorneys stipulated as to the examiner's reports. In each case the counsel did so stipulate. Based on these stipulations, the court found that each respondent had a mental illness; was unable to care for himself or herself; that the best treatment would be inpatient treatment, involuntary at AMHI; and that a term of months would be reasonable. Thus, the grounds of jurisdic-

tion and the existence of mental illness, as well as the grounds for commitment, were established and uncontested.

The court then went on to the treatment review. In the instance of Mr. Blank, it would have been quite understandable for the court to undertake a very cursory inquiry. In fact, an extensive inquiry was conducted. A licensed social worker was called to the stand. The elements of the treatment plan were described as including psychotropic and antidepressant medications; referral for a guardianship study with the Department of Human Services; supervised structured care in custody; exercise; and entry into a social learning program, not so much to learn independent living skills as self-care and social skills.

The judge entered the treatment program, with the attorneys waiving any closing statements. Since Mr. Blank had been outside AMHI only 15 days in the preceding year and had spent most of his life there, the result was a foregone conclusion. It may also seem that the judicial review of the treatment program had been surplusage. Indeed, on close examination the description of the treatment program amounted to little more than saying that Mr. Blank would be institutionalized. Yet his case was so extreme that even routine recurring review represented an important judicial function. Review of those who are institutionalized for most of their lives is essential to ensure that such people are not simply overlooked and neglected while resources are shunted elsewhere, in more promising directions. With those who return regularly to institutions, judicial review of the treatment program and process is vital not so much for what it permits as for what it prevents.

The next case, that of Carolyn LeBlanc, presented quite a different set of problems. Ms. LeBlanc was institutionalized following the death of her daughter. No charges had been brought at the time of the hearing, but it seemed clear that Ms. LeBlanc was a candidate for serious charges.

Ms. LeBlanc refused to talk with people, except in very limited terms and in limited numbers. She cried a lot. It was simply not possible, the witnesses and report said, to communicate with her or to form a diagnosis. Thus the stipulations by counsel to the reports and qualifications of the committing psychologists admitted the existence of a mental illness that in fact could not be diagnosed.

In proceeding to consider the treatment plan, the court was in a quandary. To establish whether a plan was appropriate, it would be necessary to understand the treatment needed. For that, a diagnosis was crucial, but Ms. LeBlanc's condition and manner prevented a diagnosis. The court's inquiry into treatment, then, became a way of reviewing the predicate findings for commitment. While this opportunity for review was most clear in Carolyn LeBlanc's case, it is implicit in most cases. Reviewing treatment plans is a double check on reviewing the basic reasons for committing people at all.

The first witness was Martha Fields, a psychiatric social worker. Ms. Fields testified that Carolyn LeBlanc stayed in her room in a fetal position a good deal of the time. She cried a lot. The witness said that Ms. LeBlanc seemed "to struggle mightily to communicate, but is able to do so in only very limited terms." On admission, Ms. LeBlanc had been combative, and it was necessary to put her in restraints. She had then been transferred to another unit with a different set of treatment goals.

These treatment goals, or elements, included meeting with psychiatrists for diagnosis and therapy; administration of medication, including atoban for anxiety; attempts by staff, including nursing staff and the chaplain, to engage Ms. LeBlanc in conversation, including nonverbal communication to determine what is "terrorizing" her; advocacy on her behalf to prevent further abuse by the husband and to mount a challenge to his custody of the children; and therapy with psychologists twice a week, each time for 15–30 minutes.

The witness had testified to safety concerns, cult activity, the need for monitoring prior use of narcotics, and auditory hallucinations. All of these were referred to in vague terms as apparently being in the file. The respondent's attorney and the judge questioned the witness about these. She said the "team believed" it might be helpful to contact the husband for data concerning these matters. This was true particularly of "cult activity," but when pressed on this matter, all the witness could say was that an unidentified person had spoken with the police, similarly unidentified; that the police position had been that it is "too early" to talk with her about cult activity, and that they wished to avoid a "false negative." At some prior time there had been an unidentified conversation with an institutional worker who allegedly had said that the respondent had a dream concerning human sacrifice, possibly in another institution.

That was the substance, at least to the extent it was offered, of the concern for "cult activity." Similar pressing revealed an equal lack of substance with respect to safety concerns, which were attributed to allegations by "a person in the community as to whom we cannot judge reliability." Again, when the witness was pressed, the only self-abusive conduct appeared to be that Ms. LeBlanc tends to scratch or peel away at one finger or at her thumb. The witness herself had not observed any auditory hallucinations, nor were there any entries in the file to explain that concern.

Ms. LeBlanc clearly wanted to go home and to return to her husband. This desire had been the source of crying and of "combativeness." It was a continuing concern for her, and, when asked, she would simply say that she wished to return to Manchester to her family. The respondent's attorney asked what the institution would do if Ms. LeBlanc wanted to go home to her husband. The answer was that the team would say her judgment was severely impaired and that a decision to go home would show poor judgment. This "poor judgment" would be grounds for continuing the commitment. The

desire to leave would, paradoxically, become evidence of the need to stay.

The second witness, Seymour Feld, a clinical psychologist, echoed this analysis. Dr. Feld was a stylishly dressed, heavy-set man, balding, with a beard and a ponytail. He had met with the respondent on three occasions. The first time, Ms. LeBlanc talked a bit with Dr. Feld. After that, she would say nothing. There were unusual facial expressions, grimaces, and tears. The witness said that the respondent "never lost contact with me," but he got nothing more that was useful after the first visit. He asked Ms. LeBlanc to write down her plans for after release; upon his return, he found that she had hidden herself in her room. He could not find her at once, for she had curled herself into a corner, behind the closet, in a fetal position. The morning of the hearing, she had communicated only through shrugs, raised eyebrows, and head motions, and had refused to speak. A comparison with the records of prior admissions indicated that her condition had deteriorated compared with her condition on prior discharges.

Dr. Feld did not, however, say that Ms. LeBlanc was insane, or that she *had* a mental illness. Nor did he offer a diagnosis, such as schizophrenia or manic depressive disorder or the like. Instead, he said that Ms. LeBlanc needed "asylum." She needed warmth, food, clothing and care. He was of the opinion that she would benefit from "milieu" therapy, psychiatric therapy and *some* medications. He went on to say that if she were returned to the community, Ms. LeBlanc would not be able to obtain food or shelter on her own. She would, instead, attract young men and be vulnerable in those relationships.

He was also careful to address the issue of "cult activity." In Dr. Feld's view, the term "cult" has no useful meaning. There have been serious abuses in the name of cultism in the past, but there also have been abuses of the term itself. There is a certain cult quality in all abuses. Dr. Feld had worked in a

number of contexts, including a special detail with the FBI, dealing with cult activity. He saw none in the present case.

A third witness, Mary Goetz, testified. She is a staff psychologist with AMHI and also appeared in the Harding case, as well as in others. She reported that the respondent wanted to leave and felt that she had improved through God's help. If she were to leave, she would return to her husband in Portland. When asked about the restraining order entered against her husband, Ms. LeBlanc had become tearful and withdrawn, and scrunched up on the couch. As the witness had gotten up to leave, Ms. LeBlanc had begged her to stay, sitting up on the bed and crying, gritting her teeth, clenching her hands and struggling to speak. She appeared depressed, sad and tearful and, alternately, filled with rage and anger.

The witness reported that she had observed no self-abusive behavior except picking at the area of the thumb. However, Ms. LeBlanc revealed very little of herself, and whatever conversation she undertook had very little content. She seemed to be depressed, emotionally overwhelmed, suffering from a post-traumatic stress disorder and clearly unable to care for herself. With this, the witness concluded that Ms. LeBlanc had a mental illness.

The judge approved the treatment plan and found the presence of mental illness, a likelihood of harm, that institutionalization was the least restrictive alternative, and that the time of commitment should be two months. Ms. LeBlanc never appeared in the hearing room.

The LeBlanc case is interesting for a number of reasons. To begin, the focus on the treatment plan provided a way of looking back, toward the basic diagnosis of mental illness, and forward, toward the question of returning Ms. LeBlanc to the community. In truth, these are not only alternatives, but a continuum. What is wrong with the person will cause her to be moved from the community to the institution, but because

she must at some time return to the community, it becomes necessary to look back at the underlying reasons for removing her, as well as at the services and plan available while institutionalized. What is different about the Maine system is that it enables the judge to look at the respondent through the lens of treatment, not just the lens of diagnosis or community placement.

From a different perspective, the LeBlanc case is interesting simply because diagnosis and assessment were essentially impossible. The respondent was noncommunicative. Without communication, there can be no diagnosis, at least not a meaningful one. At most it was possible to conclude that Ms. LeBlanc was upset. It might also have been possible to conclude that she would be at risk if returned to the community. Neither of these was proved by clear and convincing evidence. Moreover, even if they had been, they would not replace the necessity for finding the presence of mental illness, and the simple fact was that none had been proved.

The third point of consideration in the LeBlanc case is the absence of effective advocacy. The witnesses had not established the presence of a mental illness. Indeed, the absence of a mental illness became apparent as the hearing progressed. Yet there was no cross-examination by the respondent's attorney—or argument, for that matter—to the effect that commitment was improper because an essential jurisdictional requisite was missing. In addition, counsel failed to cross-examine on the factual basis for a number of the allegations made by witnesses about cult activity, abuse by the husband, consumption of medications, or self-abusive activity. The lack of a factual basis for this testimony emerged almost inadvertently. The witnesses, under the best of circumstances, would have consulted records that were not in evidence, and their testimony would have been hearsay. In fact, as it emerged, the testimony simply recited as fact stray bits of flotsam and jetsam that had drifted through multiple conversations and records. Was there cult activity? Somebody some-

where, in some community, had said something about that sometime, it was reported in some record somewhere. Was the respondent self-abusive? The potential had been noted as an element to be concerned about upon reporting information somewhere, sometime, and she did pick at her thumb.

What this situation does is raise the question of the role and adequacy of counsel in commitment hearings. It also raises the question of whether people in such hearings should be allowed to waive their rights, including the right to be present. Paradoxically, the very presence of respondents in hearings is often the most damaging evidence against them. Nevertheless, their absence may mean that they cannot challenge the evidence against them.

Still, it is plain throughout that the agencies, the institutions and their staff all take seriously the obligation to present a treatment plan. Although the plans are, to a considerable extent, cobbled together from pieces already in place, enough seems to be tailored to individual respondents that the hospitals are being forced to review their resources and programs, to identify the needs and potentialities of individual patients, and to try to match resources and individuals. As limited as this may be by the scarcity of resources, it is still desirable. Court review of treatment plans seems to bring it about.

Three more cases may illustrate this process. In each, the attorneys stipulated as to the qualifications of the examiners, as to the admissibility of the testimony they would offer were they to testify, and as to the contents of that testimony, which would be essentially what they had submitted in their reports. The result would be a conclusion that mental illness existed. After these stipulations, which were accepted by the court, testimony was then offered in each case as to AMHI's treatment plan.

Elizabeth Monroe was approximately 30 years of age, not unattractive, but very plainly dressed in slacks, a brown

sweater and running shoes. Her brown hair was neat and clean but without adornment. Nor was there any makeup to ease the contours of her sharp features. While she seemed to track the proceedings, her movements were somewhat awkward, and her hands were oddly configured, with the left hand curled in on itself and the right hand splayed back flat with the fingers almost at a right angle. Two or three times as the testimony on the treatment plan was presented, Ms. Monroe told her attorney that she objected to the proceedings and did not want to remain.

A licensed social worker testified as to the treatment plan. Ms. Monroe had been diagnosed as a paranoid schizophrenic. The plan therefore involved the elements of the following: (a) Haldol as a medication was needed to reduce threatening or assaultive behavior; (b) education as to the medication would have to be provided; (c) monitoring as to physical problems, concerning eating and sleeping patterns, would continue; (d) rehabilitation services would be undertaken, including those involving Ms. Monroe's interests in gardening and exercise; (e) social services would try to help her reconnect with community services on discharge, setting those up before leaving; (f) there would be an application for an administrative hearing for compulsory medication, because Ms. Monroe had resisted taking her medication; (g) they would shorten the times in confinement as Ms. Monroe got better; (h) trial visits in the community would be attempted as she improved, to make connections before discharge.

As this plan was being presented, Ms. Monroe interrupted to ask how long it would be before she went home. The response was two to three weeks. Ms. Monroe interjected that this estimate was not what had been discussed. The witness disagreed. A recess was then taken.

Judge Perry entered the usual pattern of findings: that there was a mental illness, that Ms. Monroe was likely to experience harm; involuntary hospitalization was the least restric-

tive alternative; the plan offered was acceptable, including the "convalescent provision." At that point Ms. Monroe interrupted again and said there was a problem. There then followed another recess. The findings were entered as a permanent basis for judgment, and the case was concluded.

Dorothy Lynch was a frail lady in her mid-sixties, exceptionally well dressed and groomed. She had on a cardigan sweater, a white blouse, slacks, and boating sneakers. She looked like a suburban matron who had just returned from sailing. Indeed, as the hearing proceeded, it was revealed that she had been a sailor, a suburban matron, a musical performer of considerable accomplishment, and, at least in her earlier years, a significant beauty. The usual stipulations about the report and the examining psychologist were entered. Warren Sweatt, a psychological examiner in the admissions unit, presented the treatment plan. His participation in the proceeding was somewhat noteworthy, since previously examiners had been independent of AMHI. Treatment plans had been presented by staff, but no one had presented himself or herself as a psychological examiner who had been an employee. The examiner, at least in statutory contemplation, is independent of the institution and does not participate in drafting the plan.[137] Here, however, Sweatt had attempted to draft the plan, and was attempting to testify about it. His capacity for independent judgment was inevitably subject to conflict, as evidenced by his lengthy experience with Dorothy Lynch. There had been sixteen prior admissions; this was her third admission in that calendar year.

The treatment plan Warren Sweatt presented had the following elements: (a) the diagnosis was of a bipolar mood disorder; (b) thorazine, 50 milligrams, and stelazine, 50 milligrams four times a day, were ordered; (c) once stabilized, Mrs. Lynch could spend time outside the hospital; (d) she was free to spend 10 hours a week as a volunteer in rehabilitation services, where her time had previously been used productively; (e) she and her husband would be introduced to the

center for rehabilitation; (f) her classification was "level II" as of the previous day, when she experienced some difficulty; (g) she and her husband were to receive marital counseling, since there appeared to be some difficulty; (h) the goal was to return Mrs. Lynch to her home, where she could see Dr. Whiting for medication. During the description of the treatment plan, the respondent spoke two or three times, to correct Dr. Sweatt on some of his facts or to contest some of his characterizations. However, on other occasions she nodded approvingly or supportively. She clearly was in touch with her surroundings, although on medication.

As to the medications, as noted with respect to the previous case, the issue of *compulsory* medication is not usually discussed as part of the treatment plan or the court's review, but the subject matter of the *kinds of medication* often is. The attorney general asked Dr. Sweatt why lithium had been excluded in the case of Dorothy Lynch. The respondent spoke up and said she was allergic to it. A subsequent witness, Seymour Feld, corrected this statement and said that lithium was unwise due to Mrs. Lynch's heart condition. The attorney general then asked what term of commitment was being asked for; when he was told six weeks, he asked why the term was so short. The response was that this period was geared to Mrs. Lynch's cyclical condition.

The defense counsel's cross-examination was somewhat more active than in many other cases. Questions were asked as to the time and length of observation by the witness of the respondent. Also, there was an attempt to get the witness to be more specific in the content of the jargon that was used, particularly as to whether Mrs. Lynch had stabilized. As to that, the witness testified as to what is frequently true: by the time institutional or court personnel see a person, the behavior that caused him or her to be taken into custody has either vanished or has reduced in severity. Thus the grounds of commitment, to the extent they are keyed to behavior, may be difficult to prove.

The second witness in the Lynch case was able to fill in some of the characteristics of behavior. Marie Cote testified that she had done a psychological evaluation of Mrs. Lynch. Speech was very pressured; ideation was grandiose (describing herself as a movie actress); behavior was vague and dangerous, involving a trip to the coast in the belief that the President of the United States had died and that the power squadron (of which Mrs. Lynch was a member) needed to be there to provide boats. The diagnosis was of a bipolar affective disorder, with a conclusion of severe harm coming to Mrs. Lynch from other people. There was no suggestion that she was a danger to other people or a danger to herself. Rather, with erratic, impulsive and irrational behavior, this rather frail woman might be imposed upon by others. She would be unable to protect herself.

As with the first witness, the defense attorney attempted to have the psychologist be specific as to what the respondent had said, what she believed, and how she behaved. Specificity was hard to demonstrate. For example, the witness had testified that she and Mrs. Lynch were to have a meeting, but that many things seemed to intrude to prevent Mrs. Lynch from getting there, such as going to the bathroom, washing her hands, and the like. Beyond these details, the witness could not be more specific, other than to say that she had had difficulty waiting for Mrs. Lynch.

The third witness was Seymour Feld, who had met with Mrs. Lynch two times concerning this case and who had known her for some ten years. Dr. Feld looked directly at Mrs. Lynch and spoke of their cordial relationship and of his high regard for her. At the same time, he said he had seen clinical manifestations of mania, including pressured speech, flight of ideas, lability of mood, and the like. None of this, he said, was characteristic of the respondent when she was not in the grip of a manic episode. He then reviewed, in some detail, the notes of her interview and observed that today she was much better. Yesterday she had been angry, whereas today she was

gentle and understanding, her usual condition. In the hospital she was helpful and constructive.

During all of this testimony, Dorothy Lynch had been sitting carefully poised and generally attentive. At one point she removed her cardigan and folded it lengthwise twice and across the middle once. She then placed it carefully on the chair before her. At the close of the testimony, she simply said that when she was discharged, she wanted to go on priority patient care so that if the world became "too much for her," she could come in for a day or two without being "blue blanketed." The court entered the usual findings, and commitment was ordered for no more than six weeks.

Fred Carver was a heavy-set man in his mid-sixties, with broad shoulders and a substantial stomach. He wore suspenders, with working pants rolled up at the cuffs. Closely guarded by court personnel, he stared about him with a vague expression. It became apparent that Mr. Carver was unhappy with being committed and with being in the hearing room. Counsel entered the usual stipulations, however, and a licensed social worker then entered the treatment plan. Ms. Montrose stated the elements as follows: (a) lithium and neuroleptics for a delusional disorder would be administered; (b) there would be structured activity for up to five hours a day; (c) staff would meet and talk with Mr. Carver; (d) placement in a boarding home had been added as a result of the negotiations that day, with at least four visits within 60 days of commitment *prior to* placement in the boarding home, with all of this being stepped up to as many visits as possible as early as possible; (e) discharge, as a result of the negotiations that day, would be accelerated and could be unrestricted as to geography; (f) "convalescence status" could be used as a part of the disposition, in the event that Mr. Carver became noncompliant and requested return.

After testimony much like that in the Lynch and Monroe cases, the judge entered the findings and order adopting the treatment plan.

Among the contrasts to Oregon, the Maine proceedings cast counsel in a different role. They are better informed and prepared, and are redirected to challenging treatment proposals rather than grounds of commitment. More effective pretrial screening seemed to eliminate most cases for which grounds did not exist. None of the cases observed in Maine posed the substantive difficulties observed in Oregon. This may have been because of centralized screening by AMHI, or because the state has fewer agencies, or because Maine is essentially rural. The reasons are unclear, but the result consistently was that counsel focused principally—and effectively—on treatment.

I discussed the process and performance of counsel with several attorneys and one of the veteran psychologists. They reported that at the time of my court observations, a new system of involving counsel had been initiated.

A week or so before a scheduled hearing, the defense attorney, the attorney general, the examiners, and a representative of the staff meet together. By that time the defense attorney will have had at least one meeting and possibly two with the respondent. The examiners will have conducted their examination. The staff will have prepared a tentative plan. There is then a general discussion of the grounds of commitment and the probable course of treatment. During those discussions, negotiations are undertaken to either avoid commitment or ensure effective treatment.

One consequence is far fewer contested hearings. A second consequence is that treatment plans are more detailed and more effective. A third consequence is that more cases can be processed in a single morning.

It was the opinion of all that the attorneys involved are highly motivated and highly competent. Dr. Feld is familiar with other systems, and his view is that the quality of counsel in the Maine system is superior. I asked one attorney whether court appointments in mental commitment cases are sought after, or whether they are viewed as unappealing, low-status work. His response was that they are not viewed with disdain and are not low in status. They do appeal to only a small group of highly interested people, but they result in good-quality representation. Partly this is because the level of compensation is tolerable. The attorney has stopped taking criminal court appointments because the compensation is too low, but he may receive, in commitment proceedings, as a general figure, $500. This amount makes it possible to do work that Feld feels is important, worthwhile, and professionally challenging. As to the other people on the list, each of whom serves approximately twice a year, the attorney was convinced that they undertake this work because of its social value, and the fee available is simply sufficient to make it possible to do the work.

We discussed the new system of pretrial conferencing and its value in ensuring quality of treatment. I observed that in Oregon the judges rarely get into the issue of the treatment plan, either its components or its overall quality, before or after a hearing. Maine personnel were clear that judicial and attorney involvement in the development of a plan is extremely important.

C. Some contrasts and conclusions

It is apparent that the Maine procedures are a dramatic contrast to the procedures followed in the state of Oregon. The system in Maine directly and extensively involves the judge in reviewing the treatment plan proposed for a person who is committed. Although the court does not administer treatment facilities, the judge has direct knowledge concerning those facilities and their programs. Moreover, the judge hears how they will meet the individual needs of persons committed to them, and, to some degree, the judge can insist upon modifi-

cation or revision to suit the *judge's view* of what is necessary and appropriate.

It would seem that this is constitutionally necessary. There is, after all, a right to treatment as a matter of due process. Ensuring that is a judicial function, not a function that can be left to administrative or medical judgment. Substituting judicial competence for professional competence, as a number of courts have observed, is not what the Constitution requires. What the Constitution does require, in tune with a number of federal statutes concerning disabilities and handicaps, is that a person be given a judicial review ensuring that grounds exist and that confinement will be for a purpose. The Maine approach seems vastly superior to the Oregon approach.

However, interestingly, the Maine approach gives short shrift to the one area that Oregon emphasizes. In Oregon, the hearing is chiefly about the grounds for commitment. In Maine these are rarely litigated and are instead resolved largely by negotiation between agency personnel and counsel. To some degree this procedure seems acceptable because of the system of pretrial conferencing. But just as the terms of disposition require judicial oversight, so do the grounds for commitment require judicial decision making. It may be that I observed too small a sample of Maine cases to reflect the presence of oversight in cases where grounds might well be contested. It may be, as well, that prehearing diversion processes in Maine are more effective than those in Oregon. Still, the Maine approach apparently systematically limits the judicial role in conducting oversight of commitment itself. The respondents' frequent absence from the hearing room somewhat confirms this limitation. At a minimum, their presence should be requested and even required, absent compelling circumstances, to ensure that they understand that the grounds of commitment are established and may in fact be contested by them.[138]

It may perhaps be argued that expanding the judicial function in Oregon to include oversight of disposition would not be feasible. In Maine, the hearings are conducted at the mental hospital.[139] Oregon, a somewhat larger state with a population more broadly distributed, would experience more logistical difficulties if it were to conduct all mental commitments at the mental hospital. Doing so might seem necessary to avoid burdening personnel and needlessly consuming resources. This may be doubted, however. The scheduling of hearings could be conducted in a manner that minimizes useless expenditure of time and personnel. In addition, the closing of Dammasch Mental Hospital in Wilsonville means that in the future people who are committed will be closer to the communities where they reside and where commitment proceedings are conducted. This system of community-based treatment will also mean greater variability in personnel, resources, and agency processes, in contrast to a centralized institution, as now exists in Oregon and in Maine. This is yet another reason for enhanced judicial oversight.

One clear contrast between Oregon and Maine was the familiarity in Maine on the part of both presenting counsel and defense counsel with the files, the respondents, the agency personnel, and the treating facility. The attorneys for both sides very clearly had done a considerable amount of preparation prior to coming into the courtroom. The cases, of course, are not quite comparable, since those in Maine in many instances involved people who had been in the "system" for a considerable period of time. Many of the respondents in Oregon had been in custody only a few days. Still, it is striking that the Oregon attorneys for the prosecution frequently received the files on the morning of the hearing, and the attorneys for the defense had frequently undertaken representation only a few days before and often had not even spoken with their "client."

This lack of preparation is a profound and unacceptable deficiency in the Oregon system. It should hardly need saying

that it means the respondents receive inadequate representation. What is perhaps not obvious is that the district attorney is unable to discharge his or her responsibilities not toward the public and commitment, but toward *the respondent*. The analogy and the process are very much toward criminal procedure, where the prosecuting office has an ethical obligation to protect the rights of the citizen. Those rights are not being protected in Oregon, or at least not in the cases I observed.[140]

Equally important, without effective and fully engaged counsel, the role of the judge is undercut. It became obvious to me that, in contrast to other judicial contexts, I had to become aggressive in conducting mental commitment proceedings. It would not suffice to listen to the sides present their positions and simply rule between them. It was, instead, necessary to conduct the proceedings much in the manner of an investigator seeking facts directly from the people in the courtroom, including the respondent. Although this seems, at first glance, in the interests of the respondent, a moment's reflection should make it clear that this was not so: the respondent has a right to insist that the moving party bear its burden of proof. Yet in the majority of cases, this so clearly would not happen that I undertook to inquire as to whether there were grounds for commitment—a function inconsistent with conventional judicial responsibilities and contrary to the best interests of the respondent.[141]

At the same time, it seemed clear that involving myself directly with the respondents and taking charge of the proceedings was important to the respondents. Many, if not most, of them had been at the mercy of agency and institutional personnel for days, weeks or months. It was a revelation to them that another institution could assert an interest in the protection of the rights and person of someone facing commitment.[142] Other proceedings that I have observed, both in Maine and in Oregon, lacked that feature. As with the entry of the plea of guilty in a criminal case, the direct interchange between the judge and the subject of the proceeding is

important to inform the judge that the person understands the proceedings and important to the citizen to ensure that he or she understands that there is a force of accountability to protect citizens' rights. Even if counsel and the processes surrounding a judicial proceeding were all functioning correctly, it would be the view of this author that the judges should engage directly, as appropriate, the attention and the interests of the respondent.

Finally, it became apparent as time passed with the hearings in Oregon that my earlier misconceptions and reservations required revision as to the role of the psychological examiners. It seemed initially, particularly under the Oregon statute, that they should have visited and evaluated people prior to cases being heard in the courtroom. Yet over time it became apparent that being present *while* they conducted the examination was invaluable. It meant that the psychologists themselves could be evaluated, along with the process they were conducting, as a means of then evaluating the psychologist's methodology, reports, and conclusions. It also meant, to a minor degree, that as the judge I could cover grounds or ask questions the psychologists had omitted. These might relate to psychological insights or to the factual concerns brought out during the examination.

In the knowledge of this author, there is no comparable occasion when a judge is present while examinations are being conducted. Obviously, judges are present while witnesses are being examined. However, in both civil and criminal cases, witnesses may testify as to the out-of-court endeavors leading to expert opinions on blood samples, accident reconstruction, fingerprints, or insanity. During the *testing processes*, judges are never available, nor are the other factfinders when a case is tried by a jury. A unique feature of the Oregon hearings, was that the judge could be present during the examination process and thereby gain invaluable insights.

Finally, perhaps it is implicit throughout this article that judges in mental commitment hearings need special training and continuous review concerning the philosophies of mental health, the modalities of treatment, and the quality of services available.[143] In Maine, of course, there is a routine feedback cycle present because the court sits at the mental hospital. That feedback is lacking in Oregon. However, in both states, as each closes its mental institutions and moves to a system of community-based mental health, knowledge and contact will slowly be lost and institutional memory will fade. With that will go expertise and an important resource for the protection of citizens appearing in commitment hearings.

Conclusion

The observations underlying this article were made in the early 1990s. Since that time, there has been rapid and dramatic change in the field of mental health. Both Maine and Oregon, along with a number of other states, have continued the process of downsizing and closing their institutions. Partly this is in an effort to reduce costs; partly it is in response to historic abuses at large institutions; and partly it reflects a change in the philosophy of treatment, to the effect that smaller is better. Thus the *context* in which the observations underlying this article were made is one that is changing dramatically. Yet the conclusions noted in the preceding section remain true, perhaps even more true.

A system of community-based treatment or corrections is an invitation to irresponsibility. At least when there is a large institution, such as a prison, a mental institution, or a university, it is a visible reminder that resources must be committed to those dependent upon the structure and its programs. When that visibility is gone, the reminder is also gone. The danger over the next decade or two is that the mentally ill will receive even less, not more, than before. The appearance of homeless people who have been cycled out of institutions into the com-

munity on the streets of America is testimony to this fear.[144] Formerly many of those people would have received care and treatment in institutions; now there is no assurance that they will receive either.[145]

This is at least a suggestion that community-based treatment must be carefully undertaken and monitored.[146] It may also be a reason to insist on rigor and care in the administration of mental commitment hearings. There is a paradox here. If the institutions to which people were formerly committed are no longer available, it would then seem that commitment will no longer be possible, and, in some ultimate sense, the "rights" of respondents will be protected. However, the opposite is true. The agencies that formerly picked up people and presented them for commitment may well continue to do so; but the places that formerly received them either will no longer be able to do so or will do so with such little purpose that commitment will be unavailing. Unless judges are better positioned than presently, they will be unaware of the deficiencies created by community-based treatment, and they will be unable to correct those deficiencies or to insist that they be corrected. The invisibility resulting from community-based treatment is a problem for judges fully as much as it is a problem for those who live in and administer the communities to which the mentally ill are being returned.

These comments may not be helpful in a sense of providing ready answers or easy solutions. Instead, it seems important to reconsider the ways in which we are revising our systems of dealing with the mentally ill and to ensure that we continue to commit the resources necessary to a decent and humane approach. The criticisms made in this article are made with that in mind. There is no suggestion that the people presently working in the system are anything other than well motivated or, with rare exceptions, competent. However, if the system and the structure within which they work is not designed to ensure maximum effectiveness and humane care,

then the job simply cannot be done. Nevertheless, it is a job that *must* be done.

This article closes then, with an acknowledgment of debt on the part of the author to the professionals with whom I worked and to the students who assisted in this effort, but most importantly to the people whom I met in Room 220 of the Multnomah County Courthouse in Portland, Oregon, during the year or so in which I sat as a circuit court judge *pro tempore*. It was an instructive experience, introducing me to people whose diversity and range were well beyond my previous knowledge. It was also a profoundly troubling experience, as I witnessed the anguish and the turmoil suffered by many for whom mental health and peace of mind are, at best, fragile illusions. However, the experience was, in the end, uplifting and affirming, since it reconfirmed my belief that the human spirit endures even in despair and guides the consciousness and conscience of even the most troubled individuals. To them, and for that, I owe a considerable debt of gratitude.

Notes

1. The author wishes to acknowledge his debt to the two Oregon judges who encouraged him to undertake the role of circuit judge, particularly the docket involving the mentally ill: then-Chief Justice Edwin Petersen and my esteemed colleague Circuit Judge Robert Paul Jones. Thanks also go to then-Presiding Judge of the District Court of Maine (now a superior court judge) Susan Calkins and her excellent colleague, Judge Courtland Perry, for arranging for the author to observe a number of hearings in the State of Maine. None of these judges has been asked to comment on or review this article, and all views are exclusively the responsibility of the author.

2. Names of parties, witnesses and attorneys, as well as many place names, have been changed to ensure privacy to the participants. Dates have deliberately been left indeterminate. While in some sense commitment hearings are "public," they are rarely attended by publicity. The author's regard for the citizens who came before him is high, and he has striven to avoid embarrassing participants by the case summaries presented here.

3. The author particularly wishes to express his appreciation to students Dan Russell, who observed a number of hearings, and Robin Craig,

who contributed formidable research and editing skills to this article, and—as always—to Lenair Mulford, for her patience and talent in transforming notes and ramblings into a readable manuscript.

4. To the author's knowledge, the only comparable article is an excellent piece by Professor Grant H. Morris of the University of San Diego Law School: *Civil Commitment Decisionmaking: A Report on One Decisionmaker's Experience*, 61 S. CAL. L. REV. 291 (1988). At the time of his service and during the writing of the present article, the author was unaware of Professor Morris's article. It provides a useful comparison to the experiences and conclusions reflected herein, particularly the concern for agency interaction, adequacy of resources, and clarity of definitions. Professor Morris's experience was numerically more extensive than the author's, permitting useful statistical analyses not possible here. In contrast, however, it was limited to one jurisdiction, California. The author encourages any reader interested in the present article to read Professor Morris's as well.

5. *See, e.g.*, OR. REV. STAT. 426.072 (outlining treatment and care for patients who might be committed). Historically, this dual drive emerged through two theories, *parens patriae* and the state's police power, which together simultaneously emphasize society's paternalistic protection of individuals unable to care for themselves *and* society's power to protect itself from individuals it considers dangerous or otherwise undesirable. *See* Jeffrey S. Mutnick & William Lazar, *A Practical Guide to Involuntary Commitment Proceedings*, 11 WILLAMETTE L. REV. 315, 315-317 (1975) (discussing these two theories in the context of involuntary commitment hearings); David T. Simpson, Jr., *Involuntary Civil Commitment: The Dangerousness Standard and Its Problems*, 63 N.C. L. REV. 241, 243 (1984) (discussing these two theories).

   There will be no effort here to recapture or analyze the monumental academic scholarship on the history, development and scope of civil commitment jurisprudence. A contemporary introduction is afforded. An excellent piece by Professor Bruce Arrigo, *Paternalism, Civil Commitment and Illness Politics*, 7 J. LAW & HEALTH 131 (1993), captures well the tension between state authority and personal autonomy as it plays out in mental health settings and civil commitment. For further readings, *see generally* ALBERT DEUTSCH, THE MENTALLY ILL IN AMERICA (2d ed., 1949) (1937); ANDREW T. SCULL, SOCIAL ORDER/MENTAL DISORDER: ANGLO-AMERICAN PSYCHIATRY IN HISTORICAL PERSPECTIVE 4, 10 (1989); Paul Chodoff, *The Case of Involuntary Hospitalization of the Mentally Ill*, 133 AM. J. PSYCHIATRY 496 (1976); JACK ZUSMAN, THE NEED FOR INTERVENTION: THE REASONS FOR STATE CONTROL OF THE MENTALLY DISORDERED, in CAROL A.B. WARREN, THE COURT OF LAST RESORT: MENTAL ILLNESS AND THE LAW 110-13 (1982); THOMAS S. SZASZ,

THE MANUFACTURE OF MADNESS: A COMPARATIVE STUDY OF THE INQUISITION AND THE MENTAL HEALTH MOVEMENT 1-15 (1970); BRUCE J. ENNIS, PRISONERS OF PSYCHIATRY: MENTAL PATIENTS, PSYCHIATRY AND THE LAW 2 (1972); Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54, 106 (1982); Howard H. Goldman & Joseph P. Morrissey, *The Alchemy of Mental Health Policy: Homelessness and the Fourth Cycle of Reform*, 75 AM. J. PUB. HEALTH 722 (1985); H. Richard Lamb, *The New Asylums in the Community*, 36 ARCHIVES GEN. PSYCHIATRY 129 (1979); Alexander D. Brooks, *The Right to Refuse Antipsychotic Medications: Law and Policy*, 39 RUTGERS L. REV. 339, 341 (1987); Mary L. Durham & John Q. LaFond, *A Search for the Missing Premise of Involuntary Therapeutic Commitment for Effective Treatment of the Mentally Ill*, 40 RUTGERS L. REV. 305 (1988); Stephen J. Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527, 528 (1978); THOMAS J. SCHEFF, BEING MENTALLY ILL: A SOCIOLOGICAL THEORY 1-3 (1984, 2d ed.); R.D. LAING, THE DIVIDED SELF 7-10 (1969); John Q. LaFond, *An Examination of the Purposes of Involuntary Civil Commitment*, 30 BUFF. L. REV. 499, 502 (1981); NICHOLAS A. KITTRIE, THE RIGHT TO BE DIFFERENT: ENFORCED THERAPY 59 (1972); Note, *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1191, 1222 (1974).

6. My concern was partly to abide by standards of evidence and proof before depriving a citizen of liberty. I was—and remain—equally concerned that the atmosphere and "feel" of the proceeding accord dignity to the citizen and the process, conveying the formal seriousness with which the citizen was being treated, to try to give reality to his or her rights. The extensive studies of court processes and their impact on participants are clear that people most want "fairness," a central principle of which being that they were taken seriously. Too often this is not done in mental commitment proceedings. For an excellent article *see* Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 S. METH. L. REV. 433 (1992). People view a proceeding to be fair if they are allowed to participate, are treated with respect, and are not prejudged or demeaned.

7. Absence of resources means many people are now turned back to the community—to the streets—who should be in institutions. It also means some people become dangers to themselves, or become unable to care for themselves, precisely because community support is missing. There is a complex relationship between grounds of commitment, treatment resources and ethical theory, and it plays out directly in commitment hearings. For an excellent article, *see* Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness*

and Libertarian Theory, 31 EMORY L.J. 375 (1982), on the failure of deinstitutionalization and the risks thereby created.

8. As will be seen, in Oregon—by statutory reform—judges are divorced from ordering or reviewing the place and content of treatment. This is quite different from the situation in Maine and, judging from Professor Morris's article, in California. Serious constitutional issues, in the author's opinion, are thus posed in Oregon, since ordering commitment requires finding grounds, including a disease or defect. If treatment will not follow, the commitment is invalid. *See* O'Connor v. Donaldson, 422 U.S. 563 (1975). Moreover, a "neutral factfinder" must find the need for commitment and periodically review continuing need, which implicitly involves oversight of treatment. Parham v. J.R., 442 U.S. 589 (1979).

9. The Oregon statutes are a product of significant reforms made some 20 years ago. The reformers had very definite ideas, some of quite dubious value. A history of these reforms and an analysis of their consequences may be found in two law review articles, one in the WILLAMETTE LAW REVIEW and the other in the OREGON LAW REVIEW (see Davis and Kirkpatrick, note 33).

10. For example, the Oregon Court of Appeals has upheld involuntary mental commitments when the committed person was frequently involved in fights and verbal confrontations because of a mental defect, State v. Doe, 840 P.2d 727 (Or. Ct. App. 1992), and when the committed person was a chronic alcoholic; State v. Smith, 692 P.2d 120 (Or. Ct. App. 1984). By contrast, that court overturned a commitment when the person committed called 911 because he was "wigging out," wished to escape a drug scene, and acted violently in a hospital, causing the trial judge to conclude that he was "on the verge of an explosion" and "out of touch with reality." State v. Billingsley,736 P.2d 611, 612 (Or. Ct. App. 1987).

11. "I know it when I see it." Jacobellis v. Ohio, 378 U.S. 184, 197 (1964) (J. Stewart, concurring). This is a recurring sentiment regarding mental health commitment proceedings. *See, e.g.*, David T. Simpson, Jr., Note, *Involuntary Civil Commitment: The Dangerousness Standard and Its Problems*, 63 N.C. L. REV. 241, 249 (1984) (noting an "I know it when I see it" approach to determinations of dangerousness in North Carolina civil commitments).

12. OR. REV. STAT. 426.130(2) (1993) (commitment can be for no more than 180 days).

13. Studies of people's reactions to judicial procedures affirm this observation. As summarized by Professor Tom Tyler, "[t]he first important finding of studies of people's reactions to judicial

procedures is that people are not primarily influenced by t
outcome of their experience. . . ." Tom R. Tyler,
Psychological Consequences of Judicial Procedures: Implicat
for Civil Commitment Hearings, 46 SMU L. REV. 433, 436 (1992
Instead, people are influenced by "their assessment of the fairnes
the case disposition process. People are most strongly affected
their evaluations of the procedure by which the outcomes a
reached—i.e., by their evaluations of the judicial process itself." *Id.*
at 437 (summarizing E. ALLAN LIND & TOM R. TYLER, THE SOC
PSYCHOLOGY OF PROCEDURAL JUSTICE (1988)). Moreover, "if t
socializing influence of experience is the issue of concern (i.e., the
impact of participating in a judicial hearing on a person's respect for
the law and legal authorities), then the primary influence is t
person's evaluation of the fairness of the judicial procedure itse
not their evaluations of the outcome." *Id.* (*citing* TOM R. TYLER,
WHY PEOPLE OBEY THE LAW 94-112 (1990)). Finally, studies
"consistently find that people regard procedures in which they a
allowed to participate as fairer," *id.* at 439 (*citing* LIND & TYLER,
and "that people care how they are treated by legal authorities. In
other words, they respond to whether they are treated with respect
politeness, and dignity, and whether their rights as citizens ar
acknowledged." *Id.* at 440 (footnotes and citations omitted).

14. Many of the author's experiences with mental commitment hearings are confirmed and explained in greater detail in Jeffrey S. Mutnick & William Lazar, *A Practical Guide to Involuntary Commitment Proceedings*, 11 WILLAMETTE L. REV. 315, 318 *passim* (1975).

15. Professor Grant H. Morris has made similar observations about the lack of evidence in commitment hearings in California. *See* Grant H. Morris, *Civil Commitment Decisionmaking: A Report on One Decisionmaker's Experience*, 621 S. CAL. L. REV. 291, 311 (1988) ("In many hearings, the only evidence of mental disorder was the doctor's diagnosis at the time the patient was admitted to the facility"). Even when a psychiatrist does testify, the testimony "invariably" is "that the patient was mentally ill and met the legal criteria for commitment. Except for rare exceptions, this [is] the only witness called to make the case for commitment." JAMES A. HOLSTEIN, COURT-ORDERED INSANITY: INTERPRETATIVE PRACTICE AND INVOLUNTARY COMMITMENT 62 (1993).

16. *See* Grant H. Morris, *Civil Commitment Decisionmaking: A Report on One Decisionmaker's Perspective*, 61 S. CAL. L. REV. 291, 339 (1988) (discussing the benefits of patient participation in the hearing); Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433, 439-40 (1992) (discussing the value of participation in legitimizing judicial hearings).

17. Participation either through presenting evidence and testifying or through shared decision making "enhances feelings of fair treatment." Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433, 439-40 (1992). Moreover, "people value the opportunity to present their arguments and state their views even when they indicate that what they say is having little or no influence over the third-party authority." *Id.* at 440.

18. OR. REV. STAT. 426.075(1)(a), (2) (1993).

19. Indeed, the statute requires the court to appoint examiners "sufficiently long before the hearing so that they may begin their preparation for the hearing." OR. REV. STAT. 426.075(2) (1993).

20. Professor Grant H. Morris has similarly noted that "Preparation is the key to success in certification review hearings," arguing that "a facility's case [commitments are prosecuted by the facility in California] is not likely strengthened . . . by employing a representative who is familiar with the legal basis for the patient's certification. Grant H. Morris, *Civil Commitment Decisionmaking: A Report on One Decisionmaker's Experience*, 61 S. CAL. L. REV. 291, 321 (1988).

    Relatedly, the American Bar Association's Model Rules of Professional Conduct effectively require preparation, particularly on the part of lawyers representing the respondent. *See* MODEL RULES OF PROFESSIONAL CONDUCT RULE 1.2 (1988) (requiring the lawyer to "abide by a client's decisions concerning the objectives of representation"); *id.* Rule 1.2 Comment (characterizing the lawyer–client relationship as a "joint undertaking"); DONALD H.J. HERMANN, REPRESENTING THE RESPONDENT IN CIVIL COMMITMENT PROCEEDINGS 21-24 (1985) (discussing the impact of the ABA's MODEL RULES on lawyers representing respondents in civil commitment proceedings). Similarly, the ABA has emphasized greater participation by lawyers for the state than is often observed at the hearing. *See* COMMISSION ON THE MENTALLY DISABLED, AMERICAN BAR ASSN. INVOLUNTARY CIVIL COMMITMENT: A MANUAL FOR LAWYERS AND JUDGES 47-50 (1988) (discussing the role of the state's attorney).

21. *See, e.g.*, OR. REV. STAT. 3.311(7) (1993) (allowing parties to procure witnesses); OR. REV. STAT. 23.330 (1993) (establishing procedures for subpoenaing and swearing in witnesses); OR. REV. STAT. 46.415 (1993) (requiring parties to have the privilege of presenting witnesses).

22. *See, e.g.*, OR. REV. STAT. 136.750 (1993) (allocating burden of proof in trials of violation); OR. REV. STAT. 61.005 (1993) (allocating burden of proof for affirmative defenses in criminal trials).

23. OR. REV. STAT. 40.410 (1993) (expert must be qualified "by knowledge, skill, experience, training or education").

24. OR. REV. STAT. 426.130(1)(b)(c) (1993) (providing that commitment is to the Mental Health and Developmental Disability Services Division).

25. *See* OR. REV. STAT. 426.060(2)(a) (1993) (giving the Division broad discretion regarding commitment and providing that the Division's authority is final).

26. *See, e.g.*, Thompson v. County of Medina, Ohio, 29 F.3d 238, 245 (6th Cir. 1994) (suggesting that a complete lack of mental health treatment to prisoners might constitute a deprivation of due process); Jackson v. Fort Stanton Hospital and Training School, 964 F.2d 980, 992 (10th Cir. 1992) (Fourteenth Amendment allows consideration of the availability of treatment).

27. The movement to deinstitutionalize began "shortly after World War II" and hit full stride in the 1970s. JAMES A. HOLSTEIN, COURT-ORDERED INSANITY: INTERPRETIVE PRACTICE AND INVOLUNTARY COMMITMENT XVI (1993). "In 1955, there were approximately 559,000 patients in state and county mental hospitals, with 126,498 discharges; in 1965, there were 475,202 patients and 288,397 discharges; in 1974, there were 215,573 patients and 389,179 discharges. [In 1983], it is estimated that only 138,000 patients remain in state and county hospitals." Emily Freidman, *The Light That Failed: Psychiatric Deinstitutionalization Has Betrayed Its Promise*, 57 J. AMER. HOSPITAL ASSN. 88, 88 (Aug. 16, 1983).

28. Indeed, according to Professor Perlin, "community mental health services have never been truly accessible to former state mental hospital patients." Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 90-91 (1991).

29. *See, e.g.*, Frank R. Trinity, *Shutting the Shelter Doors: Homeless Families in the Nation's Capital*, 23 STETSON L. REV. 401 (1994).

30. In particular, Oregon's Measure 5—a budget-cutting measure whose effects have shaped much of Oregon's financing throughout the 1990s—has helped bring about the closing of Dammasch State Hospital, a mental illness care facility near Portland. Adeline L. Brooks, *Dammasch Tragedy: Patients Left With No Long-Term Care*, THE OREGONIAN, Aug. 19, 1994, at D11.

31. This model is typical of most civil cases and is codified into most rules of civil procedure. In civil commitment proceedings, "[t]he legally dominated model emphasizes acting as an advocate, pressing for release of the patient even if the patient obviously appears to

need treatment." DONALD H.J. HERMANN, REPRESENTING THE RESPONDENT IN CIVIL COMMITMENT PROCEEDINGS 1 (1985) (discussing the advocate model for practitioners).

32. Professor Grant H. Morris calls this approach "the best interest model." Grant H. Morris, *Civil Commitment Decisionmaking: A Report on One Decisionmaker's Experience*, 61 S. CAL. L. REV. 291, 327 (1988). It rests on two theories common to public health litigation: *parens patriae* and police power. *See* David T. Simpson, Jr., Note, *Involuntary Civil Commitment: The Dangerousness Standard and Its Problems*, 63 N.C. L. REV. 241, 242 (1984). *See also* DONALD H.J. HERMANN, REPRESENTING THE RESPONDENT IN CIVIL COMMITMENT PROCEEDINGS 4-6 (1985) (discussing the best interests model for practitioners).

33. *See, e.g.*, OR. REV. STAT. 426.130 (1993) (outlining the court's options in a commitment hearing, which depend not only on the presence or absence of mental illness but also on the likelihood that the respondent is willing and able to get treatment). For discussions in greater depth of the Oregon mental commitment statute, see Lois Lindsay Davis, *Civil Commitment*, 16 WILLAMETTE L. REV. 437 (1979) (focusing on due process issues and statutory problems in Oregon's mental commitment statutes); Laird C. Kirkpatrick, *Oregon's New Mental Commitment Statute: The Expanded Responsibility of Courts and Counsel*, 53 OR. L. REV. 245 (1974) (outlining the provisions of Oregon's statutes after the 1973 amendments).

34. *See, e.g.*, ME. REV. STAT. ANN. tit. 34-B, § 3864(b)(A)(3) (West 1994) (conditioning commitment upon the court's satisfaction with a treatment plan). *But see also* Grant H. Morris, *Civil Commitment Decisionmaking: A Report on One Decisionmaker's Experience*, 61 S. CAL. L. REV. 291, 327 (1988) (noting that patient advocates in California "usually followed an adversarial model rather than a best interest model").

35. OR. REV. STAT. 426.070 (1993). A commitment hearing requires written notice, an investigation for probable cause by the community mental health and developmental program director, and a finding by the court "that there is probable cause to believe that the person investigated is a mentally ill person. . . ." *Id.*

36. OR. REV. STAT. 426.130(1)(b) (1993) (requiring the court to find that the person is mentally ill by clear and convincing evidence in order to commit him or her).

37. OR. REV. STAT. 426.005(1)(d) (1993) (defining "mentally ill person").

38. OR. REV. STAT. 426.130(1)(b)(c) (1993). However, commitment is only one option available to the judge after a finding of mental illness; the judge may order a conditional release and must order a release and dismissal if it is probable that a willing and able individual will in fact participate in treatment. OR. REV. STAT. 426.130(1)(b)(A) and (B) (1993).

39. OR. REV. STAT. 426.005(1)(d) (1993).

40. *Id.*

41. OR. REV. STAT. 426.495(2)(b) (1993).

42. OR. REV. STAT. 426.130(1)(b) (1993). *See also* Laird C. Kirkpatrick, *Oregon's New Mental Commitment Statute: The Expanded Responsibilities of Courts and Counsel*, 53 OR. L. REV. 245, 254-57, 262-63 (1974) (discussing the commitment standard).

43. OR. REV. STAT. 426.130(1)(b)(A) (1993). However, the Oregon Court of Appeals has emphasized that release is mandatory only if the court is, in fact, satisfied that the person will seek treatment. State v. Doe, 840 P.2d 727, 728 (Or. Ct. App. 1992).

44. OR. REV. STAT. 426.130(1)(b)(B) (1993).

45. OR. REV. STAT. 426.130(1)(b)(c) (1993).

46. *See also* Lois Lindsay Davis, *Civil Commitment*, 16 WILLAMETTE L. REV. 437, 445-47, 454-55 (1979) (discussing problems with the statute).

47. *Id.*

48. OR. REV. STAT. 426.060(1) (1993).

49. OR. REV. STAT. 426.060(2)(a) (1993).

50. OR. REV. STAT. 426.060(2)(b) (1993).

51. OR. REV. STAT. 426.070(1) (1993).

52. OR. REV. STAT. 426.070(2) (1993).

53. OR. REV. STAT. 426.070(3)(C) (1993).

54. OR. REV. STAT. 426.070(4) (1993).

55. OR. REV. STAT. 426.070(5)(a) (1993).

56. *Id.*

57. OR. REV. STAT. 426.074 (1993).

58. OR. REV. STAT. 426.074(2)(c) (1993).

59. *Id.*

60. OR. REV. STAT. 426.074(3) (1993).

61. OR. REV. STAT. 426.075(2) (1993).

62. *Id.*

63. OR. REV. STAT. 426.090 (1993).

64. OR. REV. STAT. 426.090 (1993).

65. OR. REV. STAT. 426.095(2)(a) (1993).

66. OR. REV. STAT. 426.095(e) (1993).

67. OR. REV. STAT. 426.095(4) (1993).

68. *Id.*

69. OR. REV. STAT. 426.095(4)(d) (1993).

70. OR. REV. STAT. 426.096(4)(d)(B) (1993).

71. OR. REV. STAT. 426.095(3)(b) (1993).

72. As appears in the text, the practice of the psychologists was to conduct their examinations *during* the hearings. Therefore the legal status of their reports never had to be resolved.

73. OR. REV. STAT. 426.110(2) (1993).

74. OR. REV. STAT. 426.120(1)(b) (1993).

75. *Id.*

76 OR. REV. STAT. 426.120(1)(c) (1993).

77. *Id.*

78. OR. REV. STAT. 426.120(1)(a), (2) (1993).

79. OR. REV. STAT. 426.120(2)(a) (1993).

80. OR. REV. STAT. 426.120(2)(b) (1993).

81. OR. REV. STAT. 426.120(2)(c) (1993).

82. OR. REV. STAT. 426.110(2)(b)(B) (1993) (requiring certification by the Division for any examiner who is not a licensed physician).

83. OR. REV. STAT. 426.130(1)(b)(A) (1993).

84. OR. REV. STAT. 426.130(1)(b)(B) (1993).

85. OR. REV. STAT. 426.130(1)(b)(C) (1993).

86. OR. REV. STAT. 426.130(1)(b)(C)(i) (1993). *See, e.g.*, OR. REV. STAT. 137.124 (1993) (outlining options).

87. Nevertheless, the court's discretion in sentencing is limited by Oregon's sentencing guidelines (see OR. REV. STAT. 138.222(2) (1993)), and defendants sentenced to imprisonment for felonies are committed to "the legal and physical custody of the Department of Corrections." OR. REV. STAT. 137.124(1) (1993).

88. *See* OR. REV. STAT. 426.130(1)(b)(C)(ii) (1993) (allowing that the division "may" make use of outpatient commitment).

89. The provision was added in 1987; the basic statute was passed in 1973. 1987 OR. LAWS ch. 903, § 5; 1973 OR. LAWS ch. 838, § 1.

90. OR. REV. STAT. 426.005(1)(d)(C)(iv) (1993).

91. Studies confirm these observations. *See* Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433, 439-42, 443 (1992) (discussing the psychological effects of judicial procedure on respondents in commitment hearings and noting that failure to receive satisfactory process can lead to "reluctance to accept decisions, diminished respect for the judge, mediator, or other third party, diminished respect for the courts and the legal system, and a diminished willingness to follow legal rules").

92. *See, e.g.*, Addington v. Texas, 441 U.S. 418, 427 (1979) ("the individual's interest in the outcome of a civil commitment proceeding is of such weight and gravity that due process requires the state to justify commitment by proof more substantial than a mere preponderance of the evidence").

93. *See, e.g.*, Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 71-74 (1991) (debunking many of the myths of homelessness). Perlin also notes that the shrinking housing market, reductions in government benefits, and unemployment rates have all contributed to homelessness. *Id.* at 77-79.

94. Importantly, only about one-third of the homeless population have any history of being patients in mental institutions. Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 67 (1991). Nevertheless, many of the other two-thirds "stand in clear and present danger of becoming mentally ill as their status of homelessness becomes institutionalized." *Id.* at 69.

95. While noting that "some percentage of the homeless have always been mentally ill," Professor Perlin also emphasizes that only about one-third of the homeless ever had previously been patients. Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 67, 98 (1991).

96. Indeed, the Oregon Court of Appeals has already held that "acute and chronic alcoholism constitutes a mental disorder within the definition of a mentally ill person" and hence can support involuntary commitment. State v. Smith, 692 P.2d 120, 122 (Or. Ct. App. 1984). The effect of so broadening "mental illness" could be very far-reaching. As Tom Tyler has noted, "[m]any groups affected by judicial and administrative hearings, welfare recipients, prisoners, and students are socially marginal in some respects. For those and other groups the issue of mental competence is central to issues of self-respect and security in society." Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433, 444 (1992).

97. OR. REV. STAT. 426.130(1)(b) (1993).

98. Even without closures, "the sheer volume of requests for assistance threatens to overwhelm the shelter system." Peter W. Salsich, Jr., *Homelessness at the Millennium: Is the Past Prologue?* 23 STETSON L. REV. 331, 332 (1994).

99. *See* Emily Freidman, *The Light That Failed: Psychiatric Deinstitutionalization Has Betrayed Its Promise*, 57 J. AMER. HOSPITAL ASSN. 88 (1983) (between 1955 and 1983, the number of patients in mental hospitals decreased from 559,000 to 138,000).

100. In 1993, however, President Clinton signed Executive Order No. 12,848 in the hopes of bringing more services to the homeless. 58 Fed. Reg. 9,629,517 (1993).

101. Professor Perlin emphasizes, however, that less than one-third of the current homeless population had been in mental institutions before becoming homeless. Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 67 (1991).

102. Indeed, Professor Perlin has noted that one limit on any movement to reinstitutionalize would be "that such movement inevitably diverts 'scarce resources' away from treatment of others in the community." Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness. A Story of Marginalization*, 28 HOUS. L. REV. 63, 102.

103. *See, e.g.*, OR. REV. STAT. 417.020(1) (1993) (policy statement stressing the need for supervision of juveniles); OR. REV. STAT. 419B.150 (1993) (establishing when protective custody of children is authorized).

104. *See, e.g.*, OR. REV. STAT. 105.570(1) (court can prevent district attorney from dismissing a complaint).

105. *See, e.g.*, OR. R. CIV. P. 17(c) (allowing sanctions for bad-faith pleadings).

106. *See* OR. REV. STAT. 135.360 (1993) (provisions for guilty pleas).

107. OR. REV. STAT. 426.130(2) (1993).

108. OR. REV. STAT. 426.130(1)(b), 426.005(1)(d)(A) (1993).

109. OR. REV. STAT. 426.005(1)(d)(B) (1993).

110. OR. REV. STAT. 426.005(1)(d)(C) (1993).

111. *See, e.g.*, Grant H. Morris, *Civil Commitment Decisionmaking: A Report on One Decisionmaker's Experience*, 61 S. CAL. L. REV. 291, 317-20 (1988) (discussing abuses in California mental health facilities).

112. "Perhaps no type of hearing more directly threatens a person's belief that they are an equal member of society than a mental commitment hearing. Given the stigma attached to 'insanism,' the label 'mentally incompetent' is truly a threat to the individual's ability to define themselves as an equal member of society." Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433, 444 (1992) (*citing* Michael L. Perlin, *On "Sanism,"* 46 SMU L. REV. 373 (1992)).

113. *See* OR. REV. STAT. 426.005(1)(d) (1993) (defining "mentally ill person").

114. ME. REV. STAT. 34-B, § 5476 (1994).

115. ME. REV. STAT. ANN. tit. 34-B, § 1207(1) (West 1994) (all orders of commitment are kept confidential); ME. REV. STAT. ANN. tit. 34-B, § 3864(5)(H) (West 1994) (the commitment hearing "shall be confidential and no report of the proceedings may be released to the public or press").

116. The Maine statute, however, requires that "[t]he hearing shall be conducted in as informal a manner as may be consistent with orderly procedure. . . ." ME. REV. STAT. ANN. tit. 34-B, § 3864(5)(B) (West 1994).

117. *See* ME. REV. STAT. ANN. tit. 34-B, § 3864(4)(D) (West 1994) (hearing takes place only if the examiners conclude that the person is mentally ill or "poses a likelihood of serious harm").

118. Such thoroughness, however, is not explicitly required by the statute. *See* ME. REV. STAT. ANN. tit. 34-B, § 3864(4) (West 1994).

119. The statute allows, however, "all relevant and material evidence," ME. REV. STAT. ANN. tit. 34-B, § 3864(5)(C) (West 1994), and requires that the applicant prove "that the patient is a mentally ill individual." *Id.* § 3864(5)(E).

120. ME. REV. STAT. ANN. tit. 34-B, § 3864(5)(F) (West 1994).

121. ME. REV. STAT. ANN. tit. 34-B, § 3864(5)(C)(1) (West 1994).

122. *See* ME. REV. STAT. ANN. tit. 34-B, § 3864(5)(C)(2) (West 1994) (allowing testimony from persons other than the applicant, the person for whom the hearing is being held, and that person's family).

123. *But see* ME. REV. STAT. ANN. tit. 34-B, § 3864(5)(C) (West 1994) (allowing "all relevant and material evidence").

124. *See* ME. REV. STAT. ANN. tit. 34-B, § 3864(4)(D) (West 1994).

125. ME. REV. STAT. ANN. tit. 34-B, § 3864(C) (West 1994).

126. *See* ME. REV. STAT. ANN. tit. 34-A, § 3069(2) (West 1994) (allowing voluntary commitment); ME. REV. STAT. ANN. tit. 34-B, § 3831 (West 1994) (allowing informal admission to the state mental hospital).

127. ME. REV. STAT. ANN. tit. 34-B, §§ 3864(5)(E), (F) (West 1994) (requiring the "applicant" to prove its case); ME. REV. STAT. ANN. tit. 34-B, § 3863(1) (allowing "[a]ny health officer, law enforcement officer or other person" to apply "to admit a person to a mental hospital").

128. *See* ME. REV. STAT. ANN. tit. 34-B, §§ 3864(5)(E), (F) (West 1994).

129. ME. REV. STAT. ANN. tit. 34-B, § 3864(6)(A)(1) (West 1994).

130. *Id.* § 3864(6)(A)(2).

131. *Id.* § 3864(6)(A)(3).

132. ME. REV. STAT. ANN. tit. 34-B, § 3864(5)(E)(2) (West 1994).

133. *Id.* § 3864(5)(F).

134. *Id.* § 3864(7).

135. *Id.* § 3864(6)(B).

136. The statute allows commitment only if the court can make the required findings. *Id.* § 3864(7).

137. *See* ME. REV. STAT. ANN. tit. 34-B, § 3864(5)(A)(3) (West 1994) (prohibiting court-appointed examiners from being the certifying examiners); *id.* § 3864(4)(D) (examination precedes hearing and treatment plan).

138. In fact, the Maine statute *allows* such a process but does not require it. *See* ME. REV. STAT. ANN. tit. 34-B, § 3864(5)(C)(l) (West 1994) (affording the person an opportunity to appear, to testify, and to put on witnesses). In addition, the applicant or hospital must *prove* that the person is mentally ill. *Id.* § 3864(5)(E).

Professor Morris, in his experiences with commitment hearings in California, has noted the burden-of-proof issues inherent in commitment hearings where the patient is not present. "Typically," he notes, "a patient who refuses to attend the hearing also refuses to cooperate with the patient advocate, thus making it difficult for the advocate to offer evidence to support the patient's release." Grant H. Morris, *Civil Commitment Decisionmaking: A Report on One Decisionmaker's Experience*, 61 S. CAL. L. REV. 291, 336 (1988). Nevertheless, in two such cases he released nonattending patients because of the burden-of-proof requirement. *Id.*

139. The Maine statute, however, does not strictly require the hospital setting—only that the hearing be conducted "in a physical setting not likely to have harmful effect on the mental health of the person." ME. REV. STAT. ANN. tit. 34-B, § 3864(5)(B) (West 1994).

140. Professor Grant H. Morris has expressed a similar concern regarding procedural infringements of the respondent's rights. After conducting commitment hearings in California, he recommends that "hearing officers should be empowered to decide procedural objections to their jurisdiction." Grant H. Morris, *Civil Commitment Decisionmaking: A Report on One Decisionmaker's Experience*, 61 S. CAL. L. REV. 291, 300 (1988).

141. *See* Tom R. Tyler, *The Psychological Consequences of Judicial Procedures: Implications for Civil Commitment Hearings*, 46 SMU L. REV. 433, 433-34 (1992) (upholding the value of "neutral factfinding" in commitment hearings and questioning whether procedural safeguards can ensure such neutrality).

142. Professor Morris has noted that patient participation in a commitment hearing is important even if the patient "is not released at the hearing's conclusion." Grant H. Morris, *Civil Commitment Decisionmaking: A Report on One Decisionmaker's Experience*, 61 S. CAL. L. REV. 291, 339 (1988). The Supreme Court has also recognized that the value of actually being heard goes beyond procedural due process. *See, e.g.*, Goldberg v. Kelley, 397 U.S. 54, 254, 264-66 (1970).

143. Suggestively, Professor Grant H. Morris has noted a difference in release rates between hearings officers, all of whom had legal educations, and court commissioners, all of whom had backgrounds in professions other than law. Grant H. Morris, *Civil Commitment Decisionmaking: A Report on One Decisionmaker's Experience*, 61 S. CAL. L. REV. 291, 335 (1988). However, his conclusion is that the court commissioners should acquire a legal education—not the reverse. *Id.* Moreover, he found that "hearing officers are more concerned about procedural regulations in the hearings than are court commissions." *Id.* at 338.

144. At least one study comparing American (Portland, OR) and Canadian (Vancouver, B.C.) experiences of released schizophrenic patients has noted that "Vancouver has many aftercare facilities; Portland's are fewer, and they are less well staffed and coordinated." Richard Jed Wyatt, *Scienceless to Homeless*, 234 SCIENCE 1309, 1309 (1986). As a result, "[s]chizophrenic patients in Vancouver had fewer relapses, a greater sense of well-being, and a higher degree of employment than those in Portland." *Id.*

145. *Id.*

146. *See* Grant H. Morris, *Civil Commitment Decisionmaking: A Report on One Decisionmaker's Experience*, 61 S. CAL. L. REV. 291, 351 (1988) ("In our society, liberty is valued as an unalienable right").