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# LEGISLATIVE RESEARCH COMMISSION

# MENTAL PATIENT COMMITMENTS

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## INTERIM REPORT TO THE 1985 GENERAL ASSEMBLY OF NORTH CAROLINA 1986 SESSION

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May 28, 1986

TO THE MEMBERS OF THE 1985 GENERAL ASSEMBLY (1986 Session):

The Legislative Research Commission herewith reports to the 1985 General Assembly (1986 Session) on the matter of the policies for admissions and discharges of persons who have been involuntarily committed. The report is made pursuant to Chapter 790 of the 1985 General Assembly (1985 Session).

This report was prepared by the Legislative Research Commission's Committee on Mental Patient Commitments and is transmitted by the Legislative Research Commission for your consideration.

Respectfully submitted

Liston B. Ramsey

Liston B. Ramsey

J. J. (Monk) Harrington

Cochairmen

Legislative Research Commission

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LEGISLATIVE RESEARCH COMMISSION

Senator J. J. Harrington, Cochairman
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Senator A. D. Guy
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Representative Liston B. Ramsey, Cochairman
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Representative Barney Paul Woodard

# PREFACE

The Legislative Research Commission, authorized by Article 6B of Chapter 120 of the General Statutes, is a general purpose study group. The Commission is co-chaired by the Speaker of the House and the President Pro Tempore of the Senate and has five additional members appointed from each house of the General Assembly. Among the Commission's duties is that of making or causing to be made, upon the direction of the General Assembly, "such studies of and investigation into governmental agencies and institutions and matters of public policy as will aid the General Assembly in performing its duties in the most efficient and effective manner" [G.S. 120-30.17(1)].

At the direction of the 1985 General Assembly, the Legislative Research Commission has undertaken studies of numerous subjects. These studies were grouped into broad categories and each member of the Commission was given responsibility for one category of study. The co-chairmen of the Legislative Research Commission, under the authority of the General Statute 120-30.10(b) and (c), appointed committees consisting of members of the General Assembly and the public to conduct the studies. Co-chairmen, one from each house of the General Assembly, were designated for each committee.

The mental patient commitments study was authorized by Section 16 of Chapter 790 of the 1985 Session Laws (1985 Session). That act states that the Commission may consider House Joint Resolution 1313 in determining the nature, scope and aspects of the study. Section 1 of House Joint Resolution 1313 reads: "The Legislative Research Commission may study the policies on admission and discharge of persons with mental disorders."

The Legislative Research Commission grouped this study in its Justice

area under the direction of Senator Henson P. Barnes. The Committee was chaired by Representative George W. Miller, Jr. and Senator Ollie Harris. The full membership of the Committee is listed in Appendix A of this report.

# REPORT

The Mental Patient Commitments Committee has held three meetings since January. At the organizational meeting on January 22 it discussed the current involuntary commitment law and the underlying constitutional bases for the law. Each committee member expressed his particular concerns about the commitment process. Having heard what the law provides, the Committee decided that it wanted to get a better feel for how the law actually works, as well as to hear from the participants in the process about their perception of the process and any problems with it. Therefore, at its second meeting, on March 25, the Committee heard from persons who represented almost every interest involved in the commitment process. Included in the list of speakers were the staff director of the Mental Health Study Commission, parents of patients, an area mental health authority psychiatrist, a magistrate, a former assistant attorney general who represented the state at involuntary commitment hearings, a special counsel who represents the patients in court, a district court judge, an emergency room physician who performs commitment examinations, an area mental health director, two psychiatrists from the state psychiatric hospitals, an assistant public defender, a patient advocate from a state hospital, and the Director of the Division of Mental Health, Mental Retardation and Substance Abuse. Additionally the Committee heard from representatives of the North Carolina Mental Health Association, the North Carolina Alliance of the Mentally Ill, Carolina Legal Assistance, and the North Carolina Civil Liberties Union. Unfortunately, the Committee was unable to find a former patient who would appear. A list of the speakers at the

meeting is attached as Appendix B of this report.

By the end of the second meeting the members felt they had a good understanding of the commitment process and its problems. At that meeting and at its third meeting on May 14, 1986, the Committee formulated the recommendations that are included in this interim report.

At the hearing the Committee was urged to minimize the number of changes in the statute to maximize the chance that they will be understood and used effectively by those involved. The Committee followed this recommendation.

The commitment process is a complicated one because it must balance the interest of the patient in not being held against his will and the two interests of society in protecting itself from dangerous patients and in helping mentally ill persons who cannot take care of themselves. The Committee's conclusions is that many of the problems with the commitment process are not with the law; it is basically a good law. Accordingly, the Committee's recommendations in this Interim Report include no statutory changes. However, the Committee believes that the recommendations that follow will correct some of the problems with the current procedure.

Several speakers urged the Committee to recommend that the state provide separate facilities for dangerous patients committed after having been charged with a violent crime and been found not guilty by reason of insanity or incapable of proceeding (sometimes called House Bill 95 patients). The Committee took no action on this recommendation; it is aware of that the Division of Mental Health, Mental Retardation and Substance Abuse Services (hereafter referred to as the Division) has recently begun its own investigation of how to handle all violent patients in the state hospitals. The testimony of persons not formally involved in the state system reflects a basic concern shared by many people, and the Committee thinks it is essential

that the Division deal with the problem of placing violent patients in with the general population in its study.

In addition to the recommendations made in this Interim Report, the Committee has begun consideration of some additional recommendations and is in the early phase of drafting legislative proposals which will be presented in its final report to the 1987 General Assembly. Those recommendations include other appropriations recommendations; legislation to notify family members when a patient is going to be released from a state psychiatric hospital; allowing a local examination for commitment to precede the issuance of the custody order; and notifying the judge who presided at a criminal trial where a patient was found incapable of proceeding or not guilty by reason of insanity of the time and place of involuntary commitment hearings for that patient. Additionally the Committee wishes to consider the admissibility of affidavits instead of requiring live testimony at court hearings and to further consider whether hospital physicians ought to be prohibited from releasing patients who have been admitted to the state hospital before their court hearings. The Committee also recommends that it receive an additional appropriation of $5,000 in 1986 to enable it to continue its work and prepare a final report by December of 1986.

## RECOMMENDATIONS

Expand community services for the chronically mentally ill.

Perhaps the single most agreed upon need by all persons who spoke to the Committee was the necessity to continue to expand community services for the chronically mentally ill. No matter which part of the system a person was from--a parent of a patient, an advocate for the patient, a local physician, or a state hospital physician--all agreed that the best way to solve many of the problems with the involuntary commitment process was to expand community services. The Committee recognizes that the Appropriations Committees of the North Carolina General Assembly have been providing funds for community services for this population. It urges the members of those committees to provide additional funds for expansion of those services, so that North Carolina can continue to make significant strides toward its goal of having a continuum of local services for the chronically mentally ill in all parts of the State. Such services include not only inpatient facilities and crisis stabilization programs for patients in crisis but also day programs, residential facilities, and other needed services for those patients when they are not in crisis. The Committee strongly recommends to the Appropriations Committees that if the appropriation of any additional funds for the Division is considered for fiscal year 1986, that the first priority for those funds be for the expansion of community services for the mentally ill. Although there are other areas where additional appropriations are needed to improve the commitment process, the Committee will hold any further appropriations recommendations for its final report since the number of expansion items will

be limited in the 1986 session.

Recognize the importance of the state psychiatric hospital in the current commitment system.

One of the main concerns underlying the presentations of many of the speakers before the Committee and a major concern of the committee members is the short stay of many patients who are sent from the local community to the state psychiatric hospital. There is a concern that some patients may be released when they still meet the criteria for involuntary commitment. The Committee does not want to change the commitment law to make it easier to involuntarily commit persons or to hold a committed person longer; nor does it wish to eliminate the current requirement that a physician release an involuntarily committed patient as soon as he no longer meets the criteria for commitment. Rather, the Committee is concerned that factors other than whether a patient is mentally ill and dangerous to himself or others are often considered in releasing a patient. The Committee thinks it very important that the Appropriations Committees of the General Assembly and the Division continue to recognize the importance of the state psychiatric hospitals in the commitment process. While community services are being expanded, the state hospitals will have to continue to receive patients who eventually may be served in the community. There is some concern that now state hospital physicians are having to turn away or prematurely discharge patients because of lack of bed space. And even when all needed community services are in place, the state hospitals will continue to be needed to serve the patients who need long-term hospital care. Perhaps of greater immediate concern to the Committee is that the Division has a practice of pressuring area programs to reduce their use of state facilities by threatening to cut the state and

federal funds coming to the program if their utilization of the state facility does not decrease. Such a practice discourages use of the involuntary commitment laws and in no way provides for a solution to treatment of the mentally ill who are dangerous to themselves or others. If the Division wishes to encourage community programs to handle these patients, more funds should be made available rather than cutting off funds to an area authority that heavily utilizes state facilities.

Recommend greater involvement of families in planning process.

One of the recurrent themes heard by the Committee from family members of involuntarily committed patients was that they were not kept informed of the status of the patient and had no role in planning for what would happen to him when he was released. The Committee heard a heart-rending report from one parent whose adult son was released from a state hospital, transported back to his home county, and left at a closed club house dressed in light clothes without a coat on a winter day. It was only after the man had been standing out in the cold for hours that his parents found out he was back in the community and went to help him. The Committee will recommend legislative changes in 1987 to help alleviate this problem, but it also strongly recommends that mental health professionals at the state psychiatric hospitals be encouraged to be aware of and sensitive to the feelings of family members. Also the Committee feels strongly that the best planning for the patient must involve all those who will participate in the post-release care. The Committee recognizes the patient's interest in confidentiality and does not recommend that that interest be overridden by the family member's interest in participating in the planning process regarding the patient's post-release treatment. The Committee recommends that the Division adopt a policy that

state hospital mental health professionals who are working with involuntarily committed patients discuss with those patients the importance of participation of their family in the planning process for their care after release and urge that the patient allow the family member to participate in the process. Obviously, if the patient refuses to consent to release of information to the family member, the hospital must respect that refusal. But the Committee's recommendation at least attempts to get that participation.

Recommend area authority staff participation in planning process for involuntarily committed patients.

As was mentioned in the recommendation immediately above, the participation in the state hospital's planning for an involuntarily committed patient of all persons who will be responsible for post-release treatment is critical. The Committee recommends that the Division assure that area authority staff participate in the process of determining post-release treatment for persons from their catchment area who are involuntarily committed. Presumably, area authorities who have adopted a single portal of entry and exit plan are already involved in this process, but the Committee urges the Division to assure that all authorities develop some method of participation.

Recommend increased communication between the regional hospital psychiatrists and the local community physicians.

Another problem with the current practice is that in some areas the state psychiatrists and the local physicians who send patients to the hospital apparently do not communicate well with each other. Local physicians who perform initial examinations on patients being committed feel they would

benefit from some communication from the hospital on the criteria for commitment. Obviously, it is useful for the local physicians to understand why patients are being turned away from the hospital or are being released soon after admission. The Committee recommends that the Division set up a procedure for notification of local physicians about the criteria for commitment. One approach that the Committee believes meritorious would require the Division to establish a reporting document to be sent to local physicians. It would describe the criteria for commitment and the kinds of patients who are refused admission to the hospital and would be distributed periodically to interested local physicians.

Recommend better education about commitment laws.

Several speakers before the Committee pointed out an apparent lack of knowledge about the commitment law by persons actively involved with the process. In addition, among those familiar with the law, there is a lack of consensus about the meaning of some of the laws. One answer to these problems is to increase the educational opportunity for interested parties to learn about these laws. The Committee recognizes that the Division undertook extensive training sessions when the outpatient commitment law and recodification of Chapter 122C were enacted. The Committee encourages the Division to establish other coordinated programs for the education of physicians, magistrates, judges, attorneys, families and mental health center employees on the law regarding involuntary commitment. It is a step the Committee strongly believes will reduce the level of dissatisfaction with the current process.

Recommend Attorney General study evidence used at hearings.

Another persistent issue was the consistency of procedures used by the assistant attorneys general who represent the state at the commitment hearings. There was some concern that not all available evidence is being presented to the court and whether hearings at the four hospitals use the same procedure for introducing evidence, particularly medical records. The Committee requests that the Attorney General investigate the procedures used by assistant attorneys general and report back to the Committee by August 1, 1986 regarding those procedures and any recommended changes that would assure that all records and information are available for consideration by the judge at the hearing. Specifically, the Committee requests that the Attorney General look into the questions of the admissibility of affidavits in court hearings and whether it is possible and desirable to use the same rules regarding admissibility of medical records that are followed in ordinary civil proceedings.

APPENDIX A

List of Members of Mental Patient Commitments Committee

President Pro Tem's Appointments

Sen. Ollie Harris, Cochair
Post Office Box 627
Kings Mountain, NC 28086

Mr. Cecil J. Hill
Woodside Drive
Brevard, NC 28712

Mr. Gerald Niece
120 Western Boulevard
Tarboro, NC 27886

Sen. Kenneth C. Royall, Jr.
Post Office Box 8766
Forest Hills Station
Durham, NC 27707

Sen. Daniel Reid Simpson
Post Office Drawer 1329
Morganton, NC 28655

Speaker's Appointments

Rep. George W. Miller, Jr., Cochair
3862 Somerset Drive
Durham, NC 27707

Rep. C. Melvin Creecy
Post Office Box 526
Rich Square, NC 27869

Rep. Charlotte A. Gardner
1500 West Colonial Drive
Salisbury, NC 28144

Rep. Albert S. Lineberry
Post Office Box 630
Greensboro, NC 27402

Rep. Dennis A. Wicker
315 McIntosh Street
Sanford, NC 27330

Legislative Research Comm'n Member

Sen. Henson P. Barnes
707 Park Avenue
Goldsboro, NC 27530

## APPENDIX B

### List of Speakers at Mental Patient Commitments Committee

1. Ms. Lynn Gunn, Staff Director
   Mental Health Study Commission
2. Ms. Mary Carter, NC Alliance for the Mentally Ill
3. Mr. & Mrs. Robert Hunter - Rowan County
4. Ms. Nancy Myers, NC Alliance for the Mentally Ill
5. Mr. John Baggett, NC Alliance for the Mentally Ill
6. Dr. Claire Cooper, Area Program Psychiatrist
   Durham County Area MH/MR/SA Authority
7. Ms. Barbara Muse, NC Mental Health Association
8. Mr. John Teague, Durham County Magistrate
9. Ms. Doris Holton, Assistant Attorney General
10. Mr. Steve Kaylor, Special Counsel, John Umstead Hospital
11. Judge Samuel Tate, District Court Judge
12. Dr. Jack Allison, Emergency Room Physician
    Pitt County Memorial Hospital
13. Mr. John Hardy, Area Director
    Catawba Area MH/MR/SA Authority
14. Dr. Pete Irigaray. Clinical Director, John Umstead Hospital
15. Dr. Lou Stein, Psychiatrist, Broughton Hospital
16. Dr. Paul Kayye, Director, Division of MH/MR/SAS
17. Ms. Christine Heinberg, Carolina Legal Assistance
18. Mr. Jack Nichols, NC Civil Liberties Union
19. Ms. Anne Duvoisin, Assistant Public Defender, Mecklenburg County
20. Mr. Larry Jones, Patient Advocate, John Umstead Hospital