Research Note

THE NEGOTIATION OF INVOLUNTARY CIVIL COMMITMENT

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Involuntary commitment to mental hospitals has been a topic of scholarly interest for the last twenty years. That interest has resulted in dozens of studies which have informed the legal reform of many state commitment statutes. In this paper we analyze the organizational context in which the decision to commit takes place. Relying on observations of the commitment process in an urban setting, we discuss the negotiating among the actors involved in the decision to commit. Our data suggest that formal disposition to involuntarily commit accounts for only a small percentage of those held at the hospital against their will. Court procedures and professional persuasion are used to coerce citizens into "voluntary" stays at the hospital in order to avoid court proceedings. We conclude with some thoughts about the meaning of commitment rates in light of these findings.

This study is about decision-making in a court of law. The court of law is the mental health court of a major metropolis, and the decision in question is whether to allow a hospital to confine someone unwillingly for mental illness. Scholars have been concerned with this decision-making process for well over twenty years and have sought to determine what rules or norms guide that process. In the court we studied we found that this process has many characteristics in common with decision-making in criminal court, the most important of which is the tendency to replace formal decisions with informal agreements. The key actors in the court setting work together to dispose of cases before they are formally presented to the judge. These actors, who include the public defender (PD), the state's attorney (SA), and social workers or other staff attached to the hospital, find a number of ways to dispose of cases. These include voluntary admissions and *informal* and

https://doi.org/10.2307/3053450 Published online by Cambridge University Press

procedural dispositions which involve various techniques that delay court proceedings until the hospital releases the patient, thereby mooting the action to commit.

If our analysis is persuasive, it raises important questions about the relationship between voluntary and involuntary admissions. Generally, voluntary admissions are viewed as preferable to involuntary admissions. Many reforms in commitment laws over the last twenty years have aimed at reducing coercive treatment of the mentally ill by attempting to make it more difficult to commit people to mental hospitals against their will. Most scholars have applauded this move and the increased reliance on voluntary treatment (American Psychiatric Association, 1983). The implicit assumption is that when those who are not involuntarily committed enter mental hospitals, it is not the state's coercive apparatus that has led them to seek treatment. Our discussion, consistent with the work of Warren (1977; 1982), casts doubt on this interpretation. The research reported here suggests that voluntary admissions may in fact *supplement* the coercive power of the state, serving as the lesser "charge" to which one might plead. Thus, the defendant in mental health court may accept a voluntary admission to the hospital or an informal or procedural disposition that has the same effect in order to avoid the presumed costs specially associated with an involuntary commitment (e.g., longer stays, a "record," the trauma of relatives testifying, etc.).

Voluntary admissions are in many cases devices that allow authorities to hold patients in the hospital without resorting to the time-consuming process of formal involuntary commitment. Voluntary admissions are analogous to lesser included charges in criminal cases in that they constitute a currency that allows the parties to bargain. Previous discussions (Stone, 1975) of the standards for involuntary commitment suggest a battle between the legal and psychiatric professions over the proper design and use of the process. We will show that while these professions may emphasize different concerns and values in the pages of their respective journals, they work in tandem every day to allow the hospital the discretion to treat those believed to be in need of psychiatric care. In this context the voluntary and involuntary statuses are manipulated by the key actors to produce the desired outcome: that is, a stay in the hospital.

Many devices are available to the hospital staff for keeping the admittee at the mental health facility. Figure 1 depicts the

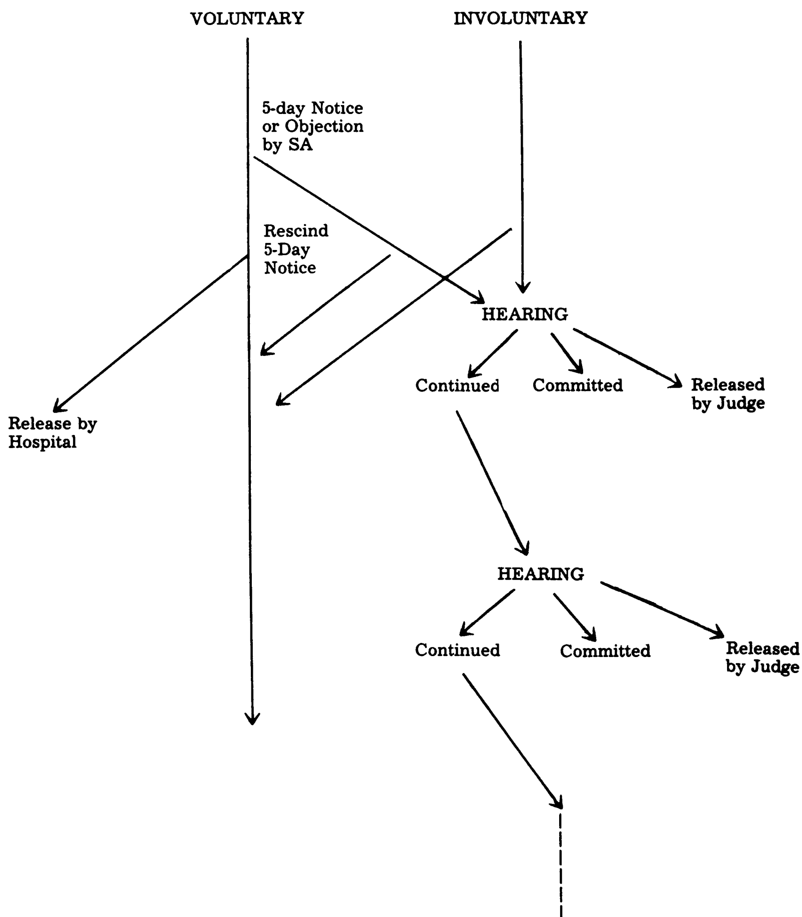
https://doi.org/10.2307/3053450 Published online by Cambridge University Press

variety of paths along which the defendant in the hospital system we studied can travel.

Broadly speaking, there are two types of patients in the mental health system, the voluntary and the involuntary admittee, each governed formally by a separate set of rules. In practice, however, little distinguishes one type of patient from the other.

On the left half of Figure 1 we depict the path of voluntary admittees, who have in theory admitted themselves to the hospital. At any time during the voluntary's stay he/she may sign a "5-Day Notice," which is a request to be released. A hearing is set up within five days, and at the hearing the patient is treated as an involuntary admittee; that is, he/she may be either committed or released. Five-Day Notices can be,

Figure 1. Paths Through Commitment



and often are, rescinded by the client, thereby returning the client to the voluntary track.

Another way in which a patient can move from the voluntary track to the involuntary is for the state's attorney to object to the patient's voluntary status. On occasion the SA will object to a voluntary commitment at the insistence of the state, the hospital, or the family. When this happens, the patient is scheduled for a hearing. For voluntary clients who neither sign a 5-Day Notice nor have their voluntary status contested, the hospital stay is either ended by the hospital through release or extended every thirty days through renewal of the voluntary. As long as a patient remains on voluntary status, the options that exist on this track can repeat themselves.

On the right-hand side of Figure 1 we depict the path along which the involuntary patient travels (Zimmerman, 1982). Patients who are involuntarily held are scheduled for a hearing before a judge. In theory only two outcomes await the client—involuntary commitment or release—to be decided at the hearing by the judge. In reality an array of procedural techniques and possibilities of informal persuasion opens clients up to a range of outcomes, most of which keep them in the hospital. The two most important of these are the continuance, which keeps the client in the hospital pending a later hearing, and the voluntary admission.

I. METHODS

The data reported here are based on field research conducted at three mental health facilities in Cook County, Illinois. The research was undertaken during a five-month period from March to July, 1980. All of the five observers involved in the study acted as special assistants to the two public defenders working in these three facilities, and the data used are the field notes of those observers. Each observer was either a third-year law student or graduate student in the social sciences at Northwestern University. All were trained in participant-observation data collection techniques. During the data collection period faculty from the Sociology Department and Law School met regularly with the observers to discuss their field notes. Because we are looking at only one county and a few actors, we cannot be sure that our results generalize throughout the country or even within Illinois. Indeed, although we only saw two public defenders in action, their different orientations had a good deal to do with what we

https://doi.org/10.2307/3053450 Published online by Cambridge University Press

observed. We expect that what we saw is one of several possible patterns of behavior that, like patterns of plea bargaining, characterize some courts or "work groups" but not others. If this is the case and if the pattern we observed is at all widespread, it has important implications for assessments of the impact of recent mental health law reforms and interpretations of the statistics on mental hospital admissions.

The person who becomes a case for the mental health court is usually someone who has been temporarily or voluntarily admitted to the state hospital and wishes to leave. If the hospital believes that confinement should continue, it must seek a court order allowing it to maintain custody. If it does so, a public defender is routinely appointed to protect the rights of the patient. Our observers accompanied the public defenders appointed in such cases as they made their rounds, spoke with clients and hospital staff, and defended clients in court. They were able to observe and record the interaction among the public defenders, the other system professionals (judges, state's attorneys, and hospital staff), and the citizen whose commitment was at issue. Thus, our information extends to the important stages of negotiations before the actual hearing as well as to the hearing itself.

The research reported here focuses on interactions between the public defender and at least one other person. Each interaction or *commitment event* was defined in terms of the potential admittee whose status was the topic of the interaction. It is these interaction events rather than the persons admitted which are our units of analysis.

The field researchers observed a total of 209 events involving 177 different people. Thus, the great majority (86 percent) of citizens observed were involved in only one event. The average number of events per person was 1.18, and the greatest number witnessed for a single individual was five. Twenty-five admittees were observed on more than one occasion. These multiple observations of the same person were distributed as follows: 1 person was observed in 5 events, 1 in 4 events, 2 in 3 events, and 21 in 2 events. Of the multiple events, 31 percent (10) were commitments and 16 percent (5) were discharges. An additional 31 percent (10) were continuances and 13 percent (4) were voluntary admissions. We classified the 3 remaining events (9 percent) as miscellaneous.

This approach means we were not always able to follow an admittee through the entire process. Important events (e.g., release) that did not include the public defender are not in our

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sample. On the other hand, the commitment process was accessible and our observation of it was guaranteed. By having five researchers working with two public defenders, we observed most of the interactions during normal working hours.

II. THE SYSTEM

When the state hospital personnel seek to hold someone who does not wish to be confined, that person becomes a "defendant" in mental health court. The participation of a state's attorney as prosecutor and a public defender on behalf of the patient is triggered by the hospital's judgment. The state's attorney is notified because it is the prosecutor's job to present the case for confinement to the court. Within twenty-four hours of the hospital's decision to hold, a public defender is assigned to the patient/defendant. The prosecutor meets with hospital personnel and the public defender to see if an accommodation can be reached. The accommodation the professionals have in mind is a voluntary commitment since the task that the prosecutor, the public defender, and others set themselves is to settle the case without going to court. The need for confinement is not at issue since the prosecutor, the public defender, and any other professionals (e.g., social workers) who may be involved defer to the hospital's judgment. Madness in the mental health court, like guilt in the criminal court, is not in question. Negotiations begin with the assumption of mental illness and end when the group disposes of the case. What is sought from both mental health defendants and their criminal counterparts is "reasonableness" in facing up to options (Sudnow, 1965). The process involves professional actors, alone and in tandem, trying to persuade the defendant to sign in voluntarily and avoid the court proceedings. The hospital staff plays the lead role in this effort, with the prosecutor and public defender assisting.

Returning to Figure 1, we can see that there are two ways that the hospital can keep a patient without making a case for an involuntary commitment at a hearing. The simplest is to persuade the patient to agree to a voluntary commitment. This act cancels the patient's "day in court" and moves the admittee to the voluntary track. The other is to have the case continued. These informal and procedural avenues provide the participants ample opportunity to negotiate the disposition of citizens without resorting to a judicial decision.

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Most studies (Hiday, 1977; Monahan, 1977) of commitment court focus on formal dispositions (either involuntary commitment or release) while ignoring the informal and "procedural" dispositions that make negotiations possible. Procedural and informal dispositions can keep the citizen in the mental health system while avoiding costly and time-consuming formal judgments. We distinguish among formal, informal, and procedural dispositions to demonstrate how court personnel maintain the smooth operation of the mental health court, and we direct the reader's attention to the array of negotiated outcomes used.

In most cases the procedural and informal dispositions represent the consensus of participants (the hospital staff, the state's attorney, and public defender, and, to a lesser degree, even the citizen and his or her family). When cases end in a formal judgment, it is usually because there has been a breakdown of cooperation and not because the participants disagree about the mental condition of the patient or feel a special need for a formal decision.

Our observations at three mental health facilities allow us to classify the kinds of interactions in which public defenders are involved. Table 1 describes the results of such interactions; that is, dispositions that were agreed upon or ordered by a court. Since our observations are an imperfect census rather than a random sample of interactions in a four-month time period, we make no claim that the results of all interactions that public defenders have with their clients and mental health officials are distributed in this way. Also, some dispositions may occur when the public defender is absent. These events do not figure in our data.

Of the events witnessed, 24 percent involved interactions that did not determine the eventual disposition of a case. These

Table 1. Distribution of Dispositions

PROCEDURAL				FORMAL			
Continuance	Voluntary	Rescind 5-Day Notice	Transfer	Commitment	Discharge at Hearing	Discharge by Hospital	Misc.
69	40	7	3	21	6	13	50
(33%)	(19%)	(3%)	(1%)	(10%)	(3%)	(6%)	(24%)

n = 209*

* 50 events were coded as "miscellaneous" because they had no bearing on the citizen's future disposition.

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events were most often informational meetings at which the client requested legal or non-legal aid or advice with respect to some personal matter. We code these as "miscellaneous" interactions. Although they represent an actual meeting between the public defender and the client, they have no bearing on the disposition. The following analysis will deal with only those events that produced a disposition.

Only 19 percent of the events witnessed involved formal outcomes, while nearly two-thirds resulted in procedural or informal dispositions. When the miscellaneous events are excluded, procedural and informal dispositions result in over 70 percent of the total number of events. It is the negotiation among the professionals over the length and terms of these dispositions that we analyze below.

III. BEDLAM BARGAINING

Procedural and informal dispositions are the most common events in the mental health system because they dispose of the cases with the least effort. A court hearing requires more time and effort spent in preparing the case by both the state's attorney and the public defender, not to mention the judge and defendant. In addition, cases usually require the court appearance and testimony of members of the hospital staff, including psychiatrists and staff workers. For the patient and family, the "costs" of a court appearance are both emotional and economic. Thus, the actors (with the possible and periodic exception of the patient) share the objective of achieving an informal disposition, but each brings to the negotiation a unique perspective that must be understood in order to account for the dispositions.

The Public Defender

According to Public Defender #1, "It's my job to prevent involuntary commitments." This public defender followed a strategy that minimized involuntary commitments by minimizing the number of formal hearings. This meant that he would often persuade clients to sign voluntaries and would often continue cases in the hope of avoiding a commitment. He also believed that the informal retention of citizens within the system was beneficial in the end. Our observer characterized the public defender's outlook on procedural dispositions in these terms:

> While the patient may have many rights, it may not be necessary or desirable for a client to exercise all of

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> these rights. For in doing so, the client may hurt himself or bring unnecessary publicity or cause a case to be delayed even further.

In essence, this public defender abandoned his adversarial responsibilities in favor of a strategy that avoided confrontation and stressed his clients' "best interests." The public defender said, "You're a social worker and an attorney here. If the patient is cooperating and working well, taking his medications, why bother him? Let him get well."

During our observations Public Defender #2 was sometimes on duty and her orientation was markedly different from that of PD #1. She saw her role as one of defending clients' rights and was much less eager to encourage voluntaries or agree to continuances. Public Defender #2 saw her job as obtaining discharge for her clients. This orientation prevailed over her own best judgments on occasion. Case 074 is one in which the patient suffered from a paranoid state and, according to the testifying doctor, "If released [the patient] will probably act on the basis of his delusions, but will probably do so within the bounds of the law." The judge subsequently discharged the patient and the observer reported, "Public Defender #2 later admitted that she did not feel good about winning this case. The patient was obviously in need of some help." This public defender's approach (which will be discussed more fully later) often caused a negotiation to break down, which, in some instances, led directly to a court appearance.

Approximately three-fourths of the events we observed were handled by PD #1. Interestingly, although their philosophies of representation differed, both PDs had the same percentage (5 percent) of cases that went to trial. This suggests that the observed differences between the public defenders affected how they settled cases before formal commit hearings, rather than the rate at which they went to trial.

The State's Attorney

The state's attorneys observed at these hospitals were also predisposed to procedural and informal dispositions. As one SA told an observer, he would "prefer to work cases out without a hearing." Both SAs and the regular PD #1 have what the PD later characterized as "a good working relationship," in which they "often negotiate compromises." The SA is guided first by the preference of the hospital staff and second by a desire to protect the prosecutor's office from mistakes. In the first case, the mechanism is evident. One SA admitted that it is the

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hospital staff that determines whether the citizen meets the legal standards for commitment, and that he follows the recommendations of the doctor even if he personally disagrees. The second mechanism is activated when the defendant has a history of violence or criminal activity. If this is the case, the SA will pursue a commitment. For example, one observer notes:

> [The SA] . . . reviews all of the voluntaries which are signed. In each case he will look at the patient's record and then decide whether or not to object to the voluntary. The SA will often challenge the voluntaries signed by those patients who have proved dangerous to others. As [the SA] explained, "I don't want any dead bodies out there with my name on them."

The SA will object to voluntaries in two ways. First, if the hospital staff regards the patient as improved and not in need of involuntary commitment, the SA can object and have the hospital staff read a statement into the record about the patient's progress. The SA will then withdraw the objection. Here the SA records an objection but still follows the cue of the hospital staff in not pursuing a commitment. The SA can also object and then continue the case. In this instance the citizen is, as a formal matter, neither voluntarily nor involuntarily committed. As the observer noted, "both strategies allow for the SA to get his objection on the record and for the PD to keep his client from being committed," although the client is still confined.

We observed two different SAs throughout the study period. They split the events observed equally between them, and they appeared to share the same attitudes about their role in the commitment process.

The Hospital Staff

The hospital staff wants the patient held for treatment or else there would be no case. The new Illinois mental health code is seen by some mental health workers, at least, as an obstacle because it does not allow the hospital to keep patients long enough to treat them properly. Since cases typically arise only after the hospital has found insanity, the primary issue from the hospital's perspective is to ensure adequate time for treatment. If the hospital's goal is to treat, informal procedural dispositions are desirable because the staff does not have to testify in court that the citizen is dangerous or incapable of self-support, and there is no risk of "losing" the patient in a court-ordered discharge. Only two actors can discharge the patient:

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the judge and the hospital personnel. The desire to reserve discretion to itself gives the hospital an incentive to press for voluntaries or to use continuances to circumvent formal involuntary commitment.

Thus, it is not surprising that the staff are active in the pursuit of procedural dispositions. PD #1 maintained that he "gets only 10 percent of all the signed voluntaries. The rest are obtained from the patients by the hospital staff." In addition, the hospital initiated close to one-third (31 percent) of all the continuances witnessed by our observers.

The Citizen

For the admittee there are several reasons to avoid a formal hearing. One is the risk of incurring the stigma of an involuntary commitment. A second is that the conditions of a voluntary commitment may be made to appear less onerous than the conditions that will attach to an involuntary commitment, should a judge so rule. A third is fear of the courtroom process itself. Fear of the courtroom process may reflect an aversion to being the focus of a formal proceeding as well as the anticipated unpleasantness of seeing friends and family testifying to one's dangerousness or inability to care for oneself and other psychic costs. One citizen we observed could not decide whether to sign a voluntary or not. The next morning nothing had changed, but when the staff told her it was time for her court appearance, she readily signed.

IV. THE TECHNIQUES OF NEGOTIATION

The Voluntary Patient

Voluntary patients, as explained earlier, are those who sign themselves into the hospital to get treatment, and by so doing waive all rights to a hearing. Although some voluntary patients have initiated or, early on, cooperated in the decision for treatment, many patients who eventually sign voluntaries originally opposed the idea.

In our observations we found that at least 28 percent of the voluntaries were signed by patients who originally resisted commitment. Because in many cases all we could determine was that a voluntary was signed, this figure may substantially understate the proportion of reluctant voluntaries.

Those who are initially resistant may sign voluntaries because they fear the courtroom process for reasons we mention above. They may also be persuaded to sign voluntaries

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by the hospital staff, the social worker, and even, sometimes, the public defender. The most common technique these persuaders use is to emphasize the "advantages" of the voluntary commitment over involuntary commitments or remaining in limbo. In addition to the common perception that voluntary commitments involve less social stigma than involuntary ones, the advantages of a voluntary include: 1) a grounds pass, allowing the client to walk around outside (an involuntary admittee is not given this privilege); 2) review within at most thirty days (commitment is for sixty days); 3) a record void of involuntary commitments; and 4) the ability to sign a 5-Day Notice at any time to set up a hearing for release.

Cases 003 and 160 illustrate how the advantages of the voluntary commitment may be used to persuade initial recalcitrants. Patient 003 originally did not want to be in the hospital, but if he was going to be there, he wanted to be able to walk around the grounds outside. Public Defender #1 explained the "advantages" of being a voluntary patient and got him to sign. In 160's case, her mother wanted her committed. Her case had been continued once by a different public defender, PD #2, who attempted to get the client released on technicalities. When Public Defender #1 took over the next week, he interviewed the patient and said to her, "This piece of paper [the voluntary] will help you get better without the court. It is entirely irrelevant what the judge says. Just sign this—it's a voluntary admission, that's all it is." Patient 160 signed it. Then Public Defender #1 went off to persuade the state's attorney not to challenge the voluntary even though the state was being pressured by the patient's family to commit the patient. This case illustrates several points. First, the influence of the professional was used to keep the patient in the hospital. Second, the public defender and the state's attorney met about the patient's future without her knowledge or consent. Third, the public defender embraced the hospital's therapeutic perspective. Finally, the public defender played on the patient's fears of going to court.

Signing a voluntary can also reflect the fact that the patient has run out of bargaining power. One example is a patient whose case had been continued four times. The continuances would not have occurred had the patient not been committed to a hearing, but she finally signed a voluntary. Our observer reported, "Apparently during the last two-week continuance the patient had stabbed another patient in the eye

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with a pencil. The [hospital] worker said that the patient now realized that she would lose if she went to court."

Continuances

As we see in Table 1, the continuance is the most common culmination of the interactions we witnessed. This is no doubt because the continuance is easier to arrange and has fewer costs than any of the other options that are open to the participants. There is no need to persuade a client, as is sometimes necessary with a voluntary, nor is there a need to present one's case to the judge. All that is required is an agreement between the public defender and the state's attorney, and this is rarely a problem. In fact, even this agreement is not strictly necessary, for either side may continue a case twice without the other side's consent. There is no formal limit to the number of times a case may be continued "by agreement." Continuances are commonplace because, as PD #1 put it, "Everybody gets their first continuance on a case."

Continuances kept the client in the hospital for an average of just under ten days.[1] They ranged from just two days to thirty-six days (one of each), but most lasted one week (31 percent) or less (34 percent). Only 16 percent were for more than two weeks. Thus, the continuance is generally a short-term strategy, but one must remember that continuances are often used more than once for the same case and voluntary commitments lapse after thirty days unless they are renewed. Thus, a series of continuances might leave a patient in the hospital without review for as long as a voluntary commitment.

Table 2 lists the actors who initiated continuances (when this was known) and the reasons offered to the court for the request. By initiator, we mean the person who suggested that a continuance be requested rather than the source of the formal motion. While one could argue that a certain amount of delay is endemic to most court proceedings, and especially ones in which the "fitness" of the defendant is a constant issue, the fact that the defendant is in treatment while awaiting trial shapes the very meaning of the continuance. For by delaying the proceedings, the hospital and state's attorney can maintain custody and treat the patient. The fact that the hospital and the state's attorney account for 60 percent of the continuances suggests that the continuance is a procedure invoked to prolong the citizen's stay informally. Indeed, if we look at the lower

[1] Based on 55 continuances for which delay information was available.

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half of Table 2, we can see that fully two-thirds of the continuances were requested in order to avoid a formal disposition that was inimicable to the interests of one of the professional initiators. The public defender (especially #1), the hospital staff, and the state's attorney all used continuances in ways that served their needs but resulted in longer stays in the hospital for the "defendant." In one-third of the cases the continuance was initiated not so much to avoid a formal disposition but rather because there were defendant-initiated or defendant-dependent reasons for the delay (e.g., the patient was physically ill, about to be discharged, or sought to call a defense witness). Furthermore, in almost all cases the continuance is agreed upon before the hearing. We found only eight cases were continued after a hearing had actually begun. That is, only 10 percent of the total number of continuances witnessed were requested during court proceedings; all the rest were agreed to beforehand, suggesting that the continuances were an accepted part of the procedure.

There are a number of reasons why actors opt for continuances. The first is so that the hospital can test or further treat the patient. When the patient is catatonic or otherwise uncooperative, the hospital will request more time to determine a treatment. In one case an observer wrote, "The hospital says they think the problem is a toxic overdose of [the patient's] medicine. They asked for a continuance. They will try to adjust his medication and perhaps release him." In

Table 2. Continuances

A.) Initiator

Hospital	State's Attorney	Public Defender	Judge	Patient	Family
19	18	9	2	12	1
(31%)	(29%)	(15%)	(3%)	(20%)	(2%)

n=61 (8 missing)

B.) Reason

To Avoid Commitment	Testing, Witness, or Worker Needed	Objection to Voluntary	Patient Ill	Further Legal Moves	Technicality
7	25	8	7	6	6
(12%)	(42%)	(14%)	(12%)	(10%)	(10%)
	68%			32%	

n=59 (10 missing)

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another instance the hospital found itself understaffed, with the doctor being "the only one on the ward and . . . too busy this week." Thus, they requested a continuance so that a diagnosis could be prepared. In short, a continuance is requested so that the hospital can do some of the things they would have done had the patient initially been voluntarily or involuntarily committed. The hospital can justify this because its actions in theory, and often in fact, will provide further evidence relevant to the court proceedings.

A second reason to continue a case is to avoid a conflict. If one or more parties disagree on the appropriate disposition, a continuance can be invoked in the hope that the passage of time will settle the dispute. In one case a patient who had stopped her medication was again taking it and doing well. However, her mother objected to the patient's release, and so the doctor asked for and got a continuance on the case. In a different example the hospital wanted to commit patient 006, a 17-year-old male. The youth did not want to be committed, nor did PD #1 want him involuntarily committed. Yet PD #1 thought the patient needed more help. After reviewing the file, he noticed that the youth's voluntary had not been renewed within the thirty days allowed. Therefore, 006 was being held illegally. Had the public defender pointed this out to the court, 006 would have had to be released. Instead, Public Defender #1 used this as leverage to get the state's attorney and the hospital to agree to a voluntary. However, 006 did not want to sign another voluntary. The hospital, on the other hand, wanted to run more tests. So the state's attorney and Public Defender #1 agreed to a thirty-day continuance of the case. This kept 006 in the hospital for as long as a voluntary so that tests could be run, but it avoided either a commitment or a voluntary.

Finally, continuances, like voluntaries, can be used to avoid the negative consequences of an involuntary commitment. Should a patient adamantly refuse to sign a voluntary, a continuance may be an alternative to an involuntary commitment. This is a favored strategy of PD #1, who sees his job as simply avoiding involuntary commitments.

> [The PD] said that he tries to get continuances in many cases since this is a way of avoiding an involuntary commitment. At the same time, he said a continuance permits additional time for treatment in the hospital. He said that if a patient is sick, he does not want to see the patient discharged.

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In 001's case, Public Defender #1 thought that the patient's case was unwinnable before the judge. Patient 001 would not sign a voluntary and the public defender did not want a commitment to tarnish 001's record and chances for a professional job or career in professional basketball. Therefore, Public Defender #1 decided that he would talk to the state's attorney and get a two-week continuance on the case. The public defender hoped that at the end of the two weeks the hospital would release the patient.

Five-Day Notices

As explained earlier, a 5-Day Notice can be signed by voluntary patients to force the hospital either to release them or to schedule a hearing before a judge. We observed 23 events that involved responses to the signing of a 5-Day Notice. As Table 3 demonstrates, 52 percent of those events involved a commitment hearing. However, 35 percent of those resulted in continuances. Of the notices witnessed by the observers, 48 percent were rescinded by the patient before the hearing. Thus, 83 percent of the events did not end in release or commitment. This often reflects the same types of pressures that are applied to those whose status has not been initially determined.

> Immediately before the hearing was scheduled to begin, PD #1 had a brief conversation with the client. He told her that she would be better off if she would rescind her 5-Day Notice. He said that the judge was likely to have her involuntarily committed for a period up to 60 days if she tried to leave. On the other hand, if she rescinded and thus remained as a voluntary patient, her stay could only last 20 days, unless she signed to stay longer. In essence, then, his message was that she would probably be out sooner if she agreed to remain a voluntary patient. The PD [#1] also told me later that he wanted to protect the girl from having an involuntary commitment on her record, which could hurt her chances of getting certain jobs in the future. The patient agreed to rescind the 5-

Table 3. 5-Day Notices

Hearings			Rescinded
Discharge	Commitment	Continuance	(no hearing)
1	3	8	11
(4%)	(13%)	(35%)	(48%)

n=23

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> Day Notice, and consequently no hearing on her case was held (Case 163).

The Breakdown of Negotiations

Twenty percent of the events we observed were at commitment hearings. Our data do not allow us to measure the incidence of commitment hearings against some appropriate base rate (e.g., people entering the hospitals), but what we did see suggests that such hearings often result from a breakdown in the negotiation processes we have just described.

When one actor decides, for whatever reason, to withdraw from the normal process of negotiation, or if the admittee is opposed to signing in and cannot be persuaded to the contrary, or if mental illness is especially severe, the result is often a hearing before the judge and a formal decision on the status of the citizen.

> The PD [#1] said that most patients either sign in or are discharged by the hospital and that about only 10 percent of the cases ever end up in court. The patients who go to court are generally in the worst condition.

A little less than a quarter of the hearings we observed resulted in continuances, and six ended with the patient's discharge.

Breakdowns of negotiations which make hearings necessary can come from many sources. Sometimes they occur after an agreed disposition is apparently in place. In one instance, our observer reports, "The state's attorney and PD #1 settled on a thirty-day continuance 'by agreement'. The judge didn't want to continue the case for another time and requested that it go to trial."

More common is the patient who won't go along, as in the following case (048):

> During the hearing the PD [#1] and the SA talked off the record. The SA wanted to know if the PD would rather continue the case. The PD said that the patient objected to this. During the recess the doctor had indicated that the patient could probably be released by the hospital in about three weeks. The patient would not agree to stay.

In this case all the requirements of negotiated settlement—the cooperation of the hospital and the offer of a continuance by the SA to the PD—were present, but the patient refused to agree to the settlement. Subsequently, the patient was discharged at the hearing because the state could not present

https://doi.org/10.2307/3053450 Published online by Cambridge University Press

clear and convincing evidence of mental illness. Alternatively, negotiations may never get off the ground when professionals disagree about norms and values.

The second PD (#2) working the hospitals studied here had a different view of her role than did the regular PD (#1). She was more inclined to defend her clients' rights and less inclined to bargain with the other side, as the following observations reveal:

> There were two cases (053, 095) where the patients were still at the hospital. Generally, these cases are automatically continued by agreement. The PD, however, would not go along with the continuances by agreement, though she did not object to the SA asking for a continuance. The SA did not want to ask for a continuance unless it was by agreement, since it would limit the SA's future use of continuance on the case.
>
> There were more confrontations between the SA and the PD concerning continuances by agreement. One new case was going to be continued for a week because the patient had to be placed in restraints. The PD refused to make the continuance by agreement, so the SA answered, "Ready." The PD answered, "Ready," and told the court staff to call the hospital staff and have the patient brought down to court even though he was still in restraints. Neither the PD nor I had ever seen the patient, since he had been in restraints yesterday and the case had been designated as continued. While this was being done, the court went on with other cases. (The continuance was granted.)

In these instances conflict between PD #2 and the SA blocked the normal process of negotiation and compromise. This appeared to be the result of her philosophy of representation, which emphasized obtaining the release of her clients. As the above example suggests, when the negotiation process breaks down, the result is more likely to be a formal disposition although informal outcomes, especially continuances, may still occur. The situation is the same as the situation in most criminal courts.

V. CONCLUSION

In the jurisdiction we studied the overwhelming majority of the cases in which the hospital moves for an involuntary commitment are "settled" by informal or procedural commitments. Most interactions in which the public defender is involved end in negotiated stays at the hospital for those whom the hospital wishes to treat.

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Perhaps the most important implication of this result is that it suggests a need to rethink the meaning of involuntary commitments. Twenty years ago it was not uncommon to see commitment rates of 90 percent (Miller and Schwartz, 1966). Hearings were often cursory, and attention to due process considerations was minimal. Contemporary studies (Shuman *et al.*, 1977; Luckey and Berman, 1979; Haupt and Ehrlich, 1980) report much lower commitment rates and greater attention to the rights of defendants (Hiday, 1977). Our findings, while perhaps of limited generalizability, suggest that we must be cautious in interpreting these lower rates. With over 80 percent of our interactions resulting in settlements outside the courtroom, it may well be that observational studies of courtroom behavior only touch the tip of the iceberg, and that psychiatric discretion still plays a major, but less visible, role in determining outcomes. Indeed, it may be that studies which report disparate outcome patterns for formal hearings reflect the effects of different court practices at the pre-hearing stage.

If psychiatric discretion has simply moved outside the courtroom, our judgment of the impact of the civil commitment reform movement must be changed. Due process guarantees are rarely upheld in hospital corridors.

As we said, this study is limited in many ways. It involves just one jurisdiction,[2] three mental hospitals, and two public defenders, one of whom was more likely to seek discharges than the other. Since our data gathering technique did not allow us to follow each case through to its final resolution, there are many unanswered questions. One of the most important of these is how the differing philosophies of the public defenders affected clients. Since both public defenders went to trial at approximately the same rates, it would seem that the strong pressure to avoid hearings had the same effect on each. Their philosophies came into play in their method of bargaining. It is conceivable that they settled their cases at different points, or struck different bargains, or both. We simply cannot tell, and it is an important issue for future research. Thus, until this study is replicated in several other locales, one must be cautious in generalizing from our findings to the situation in other areas. There is, however, some reason to believe our findings will generalize. Gilboy and Schmidt

[2] Eisenstein and Jacob (1977) report that a reliance on the dismissal at pre-trial hearings in criminal court is specific to Cook County. Other jurisdictions they studied did not rely on dismissals to dispose of cases.

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(1971: 442) also found that coercion and threats were important inducements to voluntary admissions:

> The decision on hospitalization is made on the basis of a cursory presentation of the alternatives of the admissions officer, designed to cause the individual to accept voluntary admission. The individual may, of course, be better off by admitting himself voluntarily, just as the criminal defendant may be better off pleading guilty in order to receive a lesser sentence, but the choice is a serious one and it entails a waiver of basic constitutional rights. The practices we observed show no recognition of this fact.

In addition, they report that one-third of the involuntary commitment hearings they examined ended with voluntary commitments. This "plea bargaining" has been found by others (Hiday, 1977; 1981; Miller and Schwartz, 1966). Finally, there is the obvious congruence of the processes we observed with what has been reported by numerous students of plea bargaining (Alschuler, 1968; Church, 1976; Heumann, 1978; Sudnow, 1965). The major differences appear to be that continuances play a greater role because they can be functionally equivalent to commitment, and that voluntary admission, with its greater privileges and lesser stigma, replaces the lesser included offense and the sentencing concession as the prosecutor's inducement to settle. While there are structural differences between the mental health court and the criminal court with respect to such matters as docket pressure and the parties who have an institutionalized role, when the leading legal actors represent offices that have made negotiated justice a matter of routine, it might be more surprising to find that disposition practices are different in the mental health court than to find that they are, in essence, the same.

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