INVOLUNTARY CIVIL COMMITMENT IN CHICAGO

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CHAPTER I. ACKNOWLEDGMENTS

This report owes its existence to many people and organizations. The purpose of this chapter is to acknowledge that debt and credit the contributions that have been made to the overall effort.

Two foundations provided the funds to support this work. The Chicago Community Trust was the major contributor to the research in Chicago. A significant supplement to their funding came from a grant from the John D. and Catherine T. MacArthur Foundation of Chicago. The MacArthur Foundation grant also supplemented the work of this project in three other cities: Columbus, Ohio; Winston-Salem, North Carolina; and New York City. As this report neared completion, Los Angeles was added as a fifth research site.

When these grants first were made, the Chicago Community Trust was participating in a mental health project in cooperation with several other community foundations. Their project director, on leave from the Chicago Community Trust, was Ms. Iris J. Krieg. Ms. Krieg spent an enormous amount of time helping to clarify the goals of the proposed project and to coordinate the applications for funding to the community foundations.

The management, staff, and Board of Directors of the National Center for State Courts also must be acknowledged for their contributions in making this project possible. Mr. Edward B. McConnell, Executive Director of the National Center, is responsible for giving birth to this project concept. Professor Anthony L. Guenther, of the College of William and Mary, worked as a consultant to the National Center in studying this topic and shaping the idea for a field research project. Members of the National Center's Board of Directors reviewed the project idea and commented on it from the perspective of judges. National Center library staff provided enormous aid in locating and acquiring reference materials throughout the project period. In its final stages, this project was conducted under the auspices of the Institute on Mental Disability and the Law, a subdivision of the National Center for State Courts, devoted exclusively to issues in mental disability and the law. Staff and associates of the Institute, many of whom took an active part in the project and are specifically mentioned below, are also acknowledged for their interest and help.

In the early phases of the project, we received substantive guidance from a remarkably informed group of people known collectively as our National Advisory Board. These people helped us define the critical research questions, sharpen the project goals, and develop research methods. Their names and affiliations follow:

Honorable Joseph Schneider, Chairman
Illinois Circuit Court of Cook County
Chicago, Illinois

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New York, New York

Mr. Richard P. Lynch
American Bar Association
Washington, D.C.

A special advisory group was assembled in the City of Chicago. These advisors provided detailed information about the city's mental health system and identified people who are of central importance to the functioning of that system. The Chicago advisory group was composed of these individuals:

Mr. John Schmidt, Chairman
Illinois Guardianship & Advocacy Commission

Mr. Elliot Badanes
Illinois Alliance for the Mentally Ill

Ms. Elsie Holzwarth
Committee on Mental Health
Chicago Bar Association

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Dr. Edward Sheridan
Institute of Psychiatry

Honorable Marjan P. Staniec
Illinois Circuit Court of Cook County

Dr. Helen Sunukjian
Bureau of Mental Health

For help with both advisory groups, the project owes a special debt of gratitude to Judge Joseph Schneider. Judge Schneider helped assemble these advisors and contributed significantly to their sessions.

During the field work in Chicago, many individuals helped explain and demonstrate the workings of the system. Some of these people must go unnamed -- the patients, secretaries, clerks, family members, and others who simply acted naturally and allowed us to observe as they played their parts in the system. Individuals who generously gave of their time for personal and group interviews include the following:

Mr. Elliot Badanes
Illinois Alliance for the Mentally Ill

Honorable Francis Barth
Illinois Circuit Court of Cook County

Honorable Martin Brodkin
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Dr. Helen Sunukjian
Bureau of Mental Health

Mr. Wallace Winter
Mental Health and Developmental Disability Project

Mr. Tom Riordan
Chicago Police Department

Mrs. Virginia Riley
Greater Lawn Mental Health Center

Dr. Shelly Korshak
Greater Lawn Mental Health Center

Mrs. Ruth M. Sanchez
Chicago-Read Mental Health Center

Mr. Marvin Gutenkauf
Chicago-Read Mental Health Center

Dr. Chris Lall
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Mr. Robert Murray
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Mr. Harry R. Carpenter
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Mr. Gerald Lee
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Ms. Pam Moscato
Manteno Mental Health Center

Mr. Gerald Brost
Illinois Guardianship and Advocacy Commission

Ms. Carole Anne-Jeanette Marasovic
Mental Health and Developmental Disabilities Law Project

Mr. Thomas Zelany
Cook County Public Defender's Office

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Points of view, opinions, and recommendations advanced in this report are those of the project staff only. They do not represent official policies or positions of the National Center for State Courts; any of the agencies that helped fund this research; the court systems affiliated with Chicago, Cook County, or the State of Illinois; the Illinois Department of Mental Health and Develomental Disabilities; the Chicago Board of Health, Department of Mental Health; the Chicago advisory group; or any of the individuals who participated in this research or the organizations with which they are affiliated. The author gratefully acknowledges the contributions made by these people and organizations. But all responsibility for factual errors made or opinions expressed in this report rests with the author.

CHAPTER II. SUMMARY OF RECOMMENDATIONS

The National Center for State Courts performs research that is applied in nature. Its mandate is to serve the state court systems and their allied agencies throughout the country.

This report is intended to be of practical use to the courts and agencies in Chicago that provide services to the mentally ill. Besides presenting a descriptive analysis of Chicago's system of law relating to the mentally ill, it is imperative that practical lessons be extracted from this work. These lessons are presented in the form of recommendations, which were derived from several sources. Many of the recommendations presented here were made to these researchers by people in the Chicago system. Others were made about similar situations by people at the project's other research sites. Some recommendations spring primarily from the research staff's observations of civil commitment procedures and their review of the professional literature on this topic.

Each of the major chapters of this report ends with a set of recommendations. These appear in this chapter in summary form only, without explanation. Following the complete list, explanatory comments will be made. Additional information relating to the recommendations may be found in Chapter IV.

Recommendations

A. RELATING TO VOLUNTARY ADMISSIONS

(**) The court should meet with state hospital administrators to review their reasons for their use of voluntary rather than informal admissions, and the court should not interfere with this practice unless it clearly can be shown not to be in the best interests of society and respondents. (XI.4.)

(***) Some means should be established to expedite significantly the appeal process after the rejection of a patient's application for voluntary admission to a hospital for mental health services. (XI.2.)

(**) Once an involuntary commitment proceeding has been initiated and the respondent has requested voluntary admission, if the court has any question about whether voluntary admission is appropriate or needed, it should require the filing of a second certificate of examination. If two certificates already have been filed, the court should exercise its authority to require another, independent examination. (XI.6.)

(*) After an involuntary commitment has been initiated, a respondent who is considering voluntary admission should be given more complete information about what he or she is "buying"; counsel should certify for the court that such information has been given to the patient before the court accepts the voluntary application. (XI.5.)

B. RELATING TO RESPONDENT AND PATIENT RIGHTS

(***) Written information given to respondents regarding their legal rights and protections should be rewritten in simpler language. (VI.9.)

(*) Time and care should be taken to speak personally with every respondent in order to explain clearly the respondent's legal rights and protections, and the treatment and commitment process. Prior to doing so, respondent should be asked whether he or she wishes to engage in this conversation, so that this verbal explanation of rights can be waived at respondent's request. (VI.10.)

(*) The certificate of examination should be changed to indicate clearly whether or not the examiner disclosed the respondent's right to remain silent during the examination as required by the statute. (VI.4.)

(**) A procedure should be devised by which an independent examiner can be appointed quickly and inexpensively, such examiner to be independent of the Department of Mental Health and Developmental Disabilities and to be available for examinations and presentation of results within a short period of time. (VI.7.)

(**) The mental health code should be amended to specify that a respondent has both the right to testify and the right to refuse to testify at his or her hearing. Alternatively, the Illinois Civil Practice Act should be amended to specify that the respondent in a civil commitment shall not be compelled to testify at his or her hearing. (XI.10.)

(**) All involuntarily committed patients should have guaranteed access to telephones and should be provided with a reasonable sum of money upon request if such telephones are pay telephones. (VI.11.)

C. RELATING TO EVENTS AT THE HEARING

(***) Examiners who prepare certificates should be required to report what psychiatric records and other examiners they consulted with before examining respondent and preparing the certificate. They should indicate, if possible, which of their conclusions depend substantially on their own observations and which primarily echo or reinforce prior conclusions made by others. (VI.8.)

(*) Ways should be explored to arrange that respondents who can afford to reimburse the state for the expenses of providing a public defender should do so, or should be encouraged to retain private counsel. (VII.4.)

(**) Respondent should be required to be brought to every hearing, even if a continuance is to be requested by the hospital. (VIII.4.)

(***) It should be required that at the time of a judicial hearing, the court should be informed of the complete history of medication that was provided to the patient during the prehearing period, and the probable effect that it currently has on the respondent and his or her ability to assist counsel and to testify in court. (VI.12.)

(*) Judges should further emphasize courtroom order and decorum. (VIII.1)

D. RELATING TO MATTERS OF EVIDENCE

(**) The court should encourage that specific overt acts or threats be recorded on mental health petitions whenever possible in support of the allegation that a person is dangerous to self or others or is unable to care for his or her basic physical needs. (VI.2.)

(***) Examining psychiatrists should provide, at a minimum, a full standard mental status examination report as part of the medical certification. (VI.6.)

(**) Information on previous psychiatric treatment should be admissible into evidence at the commitment hearing for purposes of diagnosis and treatment planning, but should not be accepted as sufficient evidence that respondent meets the criteria for commitment. (VIII.5.)

(**) Judges should not seek primary information about dangerousness from examiners. Rather, dangerousness should be inferred from specific threats or overt acts of respondent, reported in testimony given by petitioner and other witnesses. (VIII.2.)

(**) At recertification commitment hearings, following 60-day or 180-day commitment periods, a review of periodic treatment plans from throughout the treatment period should be required as evidence that treatment has been presented as planned and has been effective. (IX.8.)

E. RELATING TO LESS RESTRICTIVE ALTERNATIVES

(**) Prior to the judicial hearing, the mental health facility should be required to make an investigation of respondent's social and family situation and provide the findings to the judge. (VI.5.)

(**) More attention should be given to less restrictive treatment alternatives during judicial hearings. (IX.1.)

(**) Judges and attorneys should become more aware of community-based treatment programs that are available as less restrictive alternatives. (IX.4.)

(*) A system should be established so that current information is readily accessible about community-based, less restrictive treatment alternatives (LRAs) and their capacity to accept new cases. (IX.5.)

(***) In spite of all the difficulties of presenting treatment plans within the first five days of treatment, treatment plans presented to the courts during commitment hearings should be as specific as possible regarding respondent's condition and should discuss the possibility of less restrictive treatment alternatives within the hospital. (IX.2.)

(**) Consideration should be given to a practice whereby detailed treatment plans and considerations of less restrictive alternatives be undertaken only for patients who are committed. (IX.3.)

(**) Liaison should be established between the court and any community outpatient facility to which a respondent is committed in order to provide feedback to the court about the patient's treatment progress. (X.1.)

(**) Consideration should be given to a statutory change to put enforcement power into commitments to a less restrictive alternative. (IX.6.)

F. RELATING TO PROFESSIONAL DUTIES AND RESPONSIBILITIES

(**) Doctors who are to examine respondents and prepare medical certifications should be required to display a minimal fluency in oral and written English. (VI.3.)

(***) The court should continue to encourage, and further encourage, public defenders and other appointed counsel to act in the role of vigorous advocates for their clients. (VII.1.)

(***) Ways should be identified to lighten the workload of the public defenders. (VII.2.)

(*) The Mental Health and Developmental Disabilities Confidentiality Act should be amended so that counsel representing civil commitment respondents are guaranteed free access to all relevant hospital records. (VII.3.)

(***) Careful consideration should be given to the feasibility of extending staff and activities of the Guardianship and Advocacy Commission in the Chicago area by having Commission staff act as (1) liaison to community outpatient facilities, (2) patient advocates, and (3) guardians ad litem. (XI.9.)

G. RELATING TO CARE AND TREATMENT

(***) A copy of the 30-day treatment plan, which is filed with the court, should be provided to and reviewed by the respondent's attorney. (IX.7.)

(*) Procedures should be explored to facilitate the legal process of appointing guardians for respondents who are not able to provide for their basic physical needs. (XI.7.)

(*) The court and community care-providers should explore possible sources of people who could be appointed legal guardians to respondents who are not able to provide for their basic physical needs. (XI.8.)

(**) Administrators of the city mental health clinics and state hospitals should develop and implement a more cooperative procedure for referring patients from the city clinics to the state hospitals, in order to effect a significantly lower rate of admissions refusals. (XI.3.)

(***) All community mental health centers that have not already done so should establish effective ongoing liaison with state hospitals to facilitate referral of all cases in their catchment area that are denied voluntary admission by the hospital and all patients who are discharged from the hospital and would benefit from transitional support services. (XI.1.)

(***) Upon request for information about a patient, hospital staff should not automatically refuse to provide the information; rather, staff should immediately check with the patient and inquire whether or not the patient wishes to authorize release of the requested information. (XI.11.)

H. RELATING TO EDUCATION AND TRAINING

(**) Training should be made available for the Chicago police on the nature of mental health disorders, how to communicate with and handle mentally disordered people, and community resources to which mentally ill individuals may be taken. (VI.1.)

(***) An orientation should be given to inexperienced examiners who are going to testify at a hearing, prior to the time that the hearing begins. (VIII.3.)

(**) Court and state hospital officials should arrange for the preparation of a set of standard orientation materials to be used by legal and mental health professionals who become involved with civil commitment in Chicago. (XI.12.)

(**) Court and mental health professionals should arrange for periodic continuing education seminars in the Chicago area to keep people who work in this system up to date on relevant developments in law, medicine, and society. (XI.13.)

Explanatory Comments

After reading all the chapters, or simply from knowing the Chicago situation, the reader may be surprised that some recommendations have not been made. There are many issues in Chicago on which recommendations might have been offered, but were not for two reasons. First, if the Chicago system is administering a certain procedure in a manner that appears impossible to improve upon, no recommendation is made. Frequently, the lack of a recommendation may be taken as implicit agreement with the status quo. Second, in some situations the countervailing factors are so nearly weighted that any recommendation would be hard to justify and we preferred to make none rather than to present a recommendation with a weak foundation. It should be apparent after reading the report why recommendations were not made, as well as why they were.

Recommendations are made throughout the report as they arise from the textual discussions. The text is organized in an approximately chronological fashion as events would unfold relating to an individual's involuntary civil commitment. The recommendations are numbered sequentially at the end of each chapter. Thus, a recommendation labelled VII.3, for example, would be the third recommendation made in Chapter VII.

In this chapter, recommendations have been grouped in substantive categories related to the system of mental health law and practice. The chapter-based numbering system has been retained, however, with the number following each recommendation. Thus, when reading any recommendation in this chapter, one can quickly turn to the chapter from which the recommendation was taken (the first component of the recommendation's number), go to the last section of the chapter (in which the recommendations are listed), and look down the list of recommendations until the target recommendation is found (the second component of the number). A short narrative will be found explaining something about the rationale for the recommendation. The full report must be reviewed, of course, for a complete understanding of the way each recommendation relates to other elements of the system.

Recommendations are not one-dimensional. Most of them relate simultaneously to several substantive areas of concern. Thus, the groupings probably will be completely satisfactory to no one. Recommendations in any category arguably might better be listed in some other category. The research staff has placed the recommendations into the arbitrary topic groups in this chapter according to what they felt was the most important focus of each recommendation, although we are well aware that recommendations affect other aspects of the system as well. Similarly, the implementation of some recommendations will obviate or mitigate the need for others. For the sake of simplicity and brevity, however, the recommendations have been presented in this chapter in a unidimensional list.

Rating the Recommendations

Some of the recommendations are considered more far-reaching than others. A three-level system has been used for rating the recommendations. Recommendations are preceded by three asterisks (***) if they were most compelling, one asterisk (*) if least compelling, and two asterisks (**) if in between.

Several factors went into the ratings for recommendations. First, the theoretical importance of each was considered from the points of view of the law, mental health treatment, and general importance to society. (These factors are used throughout this report for evaluating the civil commitment system.) Second, thought was given to the likelihood that the recommendation could be implemented, based upon considerations of cost and procedural difficulties. If a recommendation was both theoretically important and easy to implement, it was assigned three asterisks; if theoretically unimportant and hard to implement, it was given one asterisk (if made at all). Other recommendations were rated in consideration of the trade-off between importance and difficulty.

It would be surprising, indeed, if everyone agreed on the ratings assigned to the recommendations. What is an important recommendation to one person may be not only unimportant but objectionable to another. Many points of view were considered in both writing and rating the recommendations. The research staff took final responsibility for deciding how the recommendations would appear in this report. But final responsibility for how the recommendations will be received and implemented rests with the people of the City of Chicago.

CHAPTER III. INTRODUCTION

Organization and Purpose of the Research Project

The research performed in Chicago was part of a larger effort undertaken by the National Center for State Courts. The research project began on January 1, 1981, and lasted for one year. Funding was provided by a coalition of foundations. The major funding base was a grant from the John D. and Catherine T. MacArthur Foundation, of Chicago ($100,205). Additional grants were made to enable local site participation: the Chicago Community Trust ($16,385); the Columbus Foundation ($15,010); the New York Community Trust ($16,700); and the Winston-Salem Foundation ($15,489). Additional site work planned for Los Angeles in 1982 was funded by the Della Martin Foundation ($15,000).

Two major types of products were to result from this work. The first was to be specific to each site. The second would build upon what had been learned at the sites, information in the literature, and a comparative analysis of state statutes. This latter product would be, at least in part, a procedural guide for judges who are involved with civil commitment hearings across the country.

All the information generated from the project was to be pragmatic and utilitarian. Site reports, such as this document, were intended to focus primarily on the manner in which a local system functions. Observations were to be made of how statutory provisions were implemented, where and why practice deviated from statute, and what practices were being followed that were beyond what had been anticipated by statute. Strengths and weaknesses were to be analyzed and recommendations were to be made for change and improvement.

The judge's procedural guide was also to be pragmatically oriented, but with a national perspective. It was to be a comprehensive review of how various states approach the problems of civil commitment proceedings, with commentary about which ways seem to be the best. The end result was visualized roughly as a set of procedural standards with commentary. As of the time of publication of this report, the judge's guide document has not been completed and its final form and substance have not been finally determined.

A second major phase of the research project was envisioned for 1982 and 1983, depending upon the award of funds. During a second phase, the primary activity would be dissemination of information. This is expected to be accomplished through the establishment of a civil commitment information clearinghouse, publication and wide dissemination of the judge's guide, a series of seminars and workshops for judges and other court personnel, and technical assistance to local courts as they attempt to implement changes in their system.

The Chicago Report

This report focuses on the system of involuntary civil commitment in Chicago, Illinois. It will begin by explaining how the research was done, what its limitations are, and how certain terms are used.

A. THE NATURE OF THE ANALYSIS

This descriptive analysis of the system of law for treating the mentally ill in Chicago focuses primarily on involuntary treatment. The bases for the analysis are the Illinois statute and relevant case law, professional literature in law and mental health, interviews with people who work in this system, and observations of the system at work.

Many references are made to the Illinois statute. But this report is not intended as either a definitive legal analysis of that statute or an exhaustive descriptive analysis. Reference is made to the statute to help explain why and how the system works as it does in Chicago. Interpretations of statute presented in this report should not be taken as authoritative, whether presented as the interpretations of these researchers or of people in the field.

Neither is this report to be taken as a scholarly analysis of issues. It contains no citations to professional literature, although an enormous literature exists that is relevant to this work. Scholarly works abound on mental health law and civil commitments, including some produced by the staff of this project. (For example, see Zimmerman, "Involuntary Civil Commitment: The Discerning Eye of the Law," State Court Journal, 1981, 5(4), 5ff. Copies are available from the National Center for State Courts.) To cite professional literature as it relates to the manifold aspects of this report would have been an enormous task and would have increased the bulk of this report significantly. We thus chose not to cite these works, leaving scholarly analyses to other reports in which they already have been done quite well. Our obvious debt to the scholarly work of others in this field is readily acknowledged, however, and will be easy to identify in the pages that follow. We make no pretense that the philosophical and technical ideas raised in this volume are original thoughts, and we apologize in advance to the numerous authors to whom we fail to give credit.

Then what is this report? This report describes how informed people, who work with civil commitment in the City of Chicago, perceive the system to work. It is a report of what they do, what they feel about it, and what they have suggested about other ways it might be done. While we do not claim to present authoritative knowledge either about the law or scholarly thought in this area, we do claim to be presenting an accurate and representative report of the opinions and practices of the people who are central to the Chicago system for civil commitment.

All that we know about the system is what we have been told by the people in Chicago, supplemented by the professional literature and a limited number of personal observations. When it is reported that certain events occur in Chicago, it should be understood that this means we were told that those events occur, or that we observed them occur. If specific sources of information are not cited, it can be assumed that this information was reported to these researchers by virtually all those who were interviewed and observed. If information came only from certain sources, or if it differed from information from other sources, then the specific source of the information is reported.

All sources are reported as generic categories of people, such as judges, attorneys, doctors, mental health professionals, and so on. Specific names are not used. We have attempted to maintain confidentiality of the information that was provided to us. We promised that names would be removed from all data so that particular persons could not be associated unambiguously with particular bits of information provided to us.

Appendix C is a copy of the data-collection guides used to collect information in Chicago. Also included in those materials is a statement of research ethics and confidentiality, which directed this work. A complete set of field notes, with names of people removed, can be obtained from the National Center for State Courts.

The analysis is organized roughly chronologically, proceeding from prehearing events, through the hearing, to posthearing. A separate section concerns the respondent's counsel, who usually comes into the picture after a person has been taken into custody but before a hearing and whose involvement may last through the posthearing period. A final chapter discusses some special topics that are not specific to any part of the civil commitment sequence of events or that present a set of issues somewhat apart from the customary concerns. This organization also is followed, more or less, in the statutory analysis contained in Appendix A. While another means of organizing these materials might arguably have been more effective, this general organization scheme was used in order to provide maximum comparability between these Chicago materials and those that the project prepares for other sites and for general use.

The report and its recommendations have been reviewed by many people in Chicago. Nevertheless, the final responsibility for its contents rests with the staff of this project. Chapter I lists the individuals who served this project in the capacity of advisors and data sources. Either through interviews or our observations of their activities, they are the source of all our knowledge about the Chicago system. They also have been given the opportunity to review the report before its final release, to detect and correct errors, and to suggest revisions in the recommendations. No topic of this complexity can generate a perfect unanimity of opinion, however. Differences in perceptions are acknowledged as much as possible. When conclusions or recommendations had to be fixed in one direction or another, though, the

final decisions were made by research staff and it is they who must be accountable for whatever degree of wisdom or folly was thereby created.

B. LIMITATIONS

Every research effort has its limitations. These need to be acknowledged so that the conclusions in the report are not generalized to situations to which they do not apply.

This report applies only to the process of civil commitment in the City of Chicago. It is not meant to apply to any other parts of the State of Illinois, or even to Chicago's nearby suburbs. Some parts of the information certainly will generalize beyond the City; but generalizations to other areas must be made by the reader as fortuitous and serendipitous offshoots of this work, not as the intention of these researchers. Other products coming from this research project will establish some general lessons that might be applied nationwide, but that will not be the intent of this report.

The data for this report were gathered during September 1981. The final report was released in review draft at the end of 1981. The report is accurate as of that time. In performing policy analysis and making recommendations for change, one implicitly hopes that the report soon will be out of date. The longer a situation remains unchanged, the longer the report remains accurate and the greater the evidence that it had no impact.

This report relates only to the mentally ill adults of Chicago who are in the civil system of law. It is not meant to be accurate with reference to prisoners, minors, or the mentally retarded or developmentally disabled. Some of this report has obvious relevance to these special populations of people. Those populations also are subject to special considerations, however, that seriously qualify this report's applicability to them.

C. TERMINOLOGY

Some terms that deserve special comment are used throughout this report. These will be noted here and will not be repeated as the terms are used.

The most important term is the word "commitment" and its various forms and derivatives. The current vogue is not to use this word because of its strong negative connotations. In its place, most people are using the term "hospitalization." We have chosen, though, to use "commitment" in this report for two reasons. First, it is a term that is commonly used in speech, readily recognized, and well understood. Second, in Illinois and several other states, commitment and hospitalization are not synonymous. Hospitalization is merely one form that an order of commitment may take. Commitment is more nearly synonymous with "court-ordered treatment," but this is not exactly accurate either in a

system such as Illinois's in which a patient, though committed, still retains the right to refuse treatment. While the term "court-ordered" might be a good substitute term for "committed" in Illinois, statutes in other states make it possible for people to be committed without the involvement of a court. Thus, the search for a synonym is frustrated and the choice is made to use the word "commitment" despite the stigma that has been associated with it. Perhaps the ultimate solution to this problem will be reform of civil commitment law and mental health practices, and subsequent re-education of the public, so that the stigma, not the word, eventually disappears.

Two other words used frequently in this report are "respondent" and "patient." These words are essentially synonymous for purposes of this report. Technically, a patient is a person who has been admitted for mental health treatment, with or without a court commitment, either as an inpatient or outpatient. (Outpatients are more frequently referred to as "clients" by mental health professionals, but they will be called "patients" in this report.) A respondent is a person who is the subject of an involuntary commitment proceeding. Generally, the report refers to the person as "respondent" with regard to legal concerns and before a commitment has been ordered. The person is referred to as a "patient" with regard to treatment concerns and following a commitment or voluntary admission to treatment.

Another term that arises is "these researchers." Associated terms are "we," "project staff," "our," and so on. These terms refer to staff members of the National Center for State Courts who participated in this research project. They are listed by name in Chapter I. The project benefited immensely from many hours of sharing knowledge, observations, notes, ideas, and opinions. A result of the sharing process, however, is the impossibility of fixing responsibility for the genesis of any of the accumulated project wisdom to any single individual. The task of being primary author for this report fell to Joel Zimmerman, however, and it is he who bears responsibility for its accurate chronicling.

Several bodies of law are mentioned frequently in the report. First and foremost is the law referred to as "the Illinois statute," "the Mental Health Code," or simply "the statute." These all refer to the Mental Health and Developmental Disabilities Code (Ill. Ann. Stat., ch. 91 1/2, Smith-Hurd Supp. 1981-1982).

Related to the Illinois statute, references are made throughout the report to the "1976 Governor's Report" or the "Governor's Report." More accurately, this is reference to a document entitled Report: Governor's Commission for Revision of the Mental Health Code of Illinois. It was printed in 1976 and is available through state officials. The document, an excellent treatise on mental health law, made suggestions for revision and replacement of the then-current mental health statute. This is considered to be an authoritative sourcebook for understanding the intent of the current statute. A great proportion of the Governor's Report was enacted into law as recommended.

Two other pieces of legislation, both also stemming from the Governor's Report, also are referred to. The first is the Guardianship and Advocacy Act. The second is referred to as the "Confidentiality Act" or by its more accurate title, the "Mental Health and Developmental Disabilities Confidentiality Act." (Both are part of Ill. Ann. Stat., ch. 91 1/2, Smith-Hurd Supp. 1981-1982.)

CHAPTER IV. METHODOLOGY

This chapter considers methods used in the national project undertaken by this research staff, as well as in the project work specific to Chicago.

Literature Review

Beginning in January, 1981, the project staff reviewed professional literature on the topic of mental health law. The initial process lasted for approximately two months, although literature was reviewed continually throughout the one-year project period. Source materials were collected from books and journals in the disciplines of law, psychiatry, psychology, social work, sociology, and public policy administration. Professors and mental health practitioners were informed about the project and asked to provide copies of unpublished papers or other hard-to-find articles that would be of value to our work. Members of the project's national advisory board were particularly helpful in steering us to valuable literature.

Just prior to the meeting of the national advisory board in April, staff prepared an "Issues Paper" summarizing the relevant literature and defining important contemporary issues of civil commitment with which this project was to be concerned. The substantive portion of the "Issues Paper" has been altered slightly and published as "Involuntary Civil Commitment: The Discerning Eye of the Law" (State Court Journal, 1981, 5(4), 5 ff.), copies of which are available from the National Center for State Courts Publication Department. At their meeting, members of the board helped staff decide what research questions should be explored during site visits and gave counsel on field research methods.

Statutory Review

A scheme was devised for analyzing statutes governing civil commitment. The scheme was constructed by identifying all the important questions that might be addressed in a commitment statute and then ordering them roughly as they might become relevant in a typical case. The statutory analysis outline and the full analysis of the Illinois statute are appended to this report as Appendix A.

A complete statutory analysis was performed for approximately 20 states, as well as for the model statute prepared by the Mental Health Law Project (published in the July-August 1977 issue of the Mental Disability Law Reporter). The 20 states were those in which the National Center's project had received funding, or states that had been brought to the staff's attention as having statutes that were particularly interesting, innovative, or modern.

After an individual review of all the statutes, a comparative analysis was made. Using the analytical scheme that had been developed, staff compiled all the variations of statutory provisions relating to each of the analytical categories. This compilation of statutory variations is available from the National Center and eventually will form the basis for a major project document that will be published as a guide for judges. Based upon this analysis, staff determined where and how state statutes and procedures differed with regard to civil commitment. These points of difference became the focus for field data collection.

In addition to reviewing statutes, staff reviewed important case law. The Mental Disability Law Reporter, law review articles, and statute annotations available for the various states were the major sources for identifying important cases. Where the case law significantly added to or changed the range of variation that had been identified through the statutory analysis, this information was incorporated in the comparative analysis. Particularly thorough analyses of case law were conducted for the four funded project states: Illinois, Ohio, North Carolina, and New York.

Project staff also contacted court administrators across the country to obtain any types of administrative regulations that might be of help. Several copies of regulations were received. For all states whose statutes were analyzed, published court rules also were examined. Information gleaned from administrative regulations and court rules was sparse, but it also was included in the statutory analysis as appropriate.

Preliminary Site Visits

A preliminary visit was made to each of the four funded project sites. Three staff members visited Chicago on April 13 and 14, meeting with individual members of the Chicago advisory board, and with the board as a group.

The preliminary visit served several purposes. First, advisory board members told staff their perceptions of how the Chicago system worked. They noted problems with the system and peculiarities that set it aside from most others and answered questions about the Illinois statute.

During the preliminary visit, cooperation was pledged for the National Center's research project. The people in Chicago (and in the other sites as well) were extremely helpful and cordial. Staff of the courts and the mental health agencies invited the research team to include them in the data collection effort and offered to help in any way they could.

The Chicago advisors identified all the agencies and institutions in Chicago that were involved with the mentally ill and civil commitment. Key people within these organizations were named. Others who were unrelated to major institutions but who were important or knowledgeable in the area also were identified.

Site Visits

Intensive data-collection trips to each of the four funded sites followed the completion of the comparative statutory analysis. Four staff members worked in Chicago from September 7 to September 11.

During the week prior to the site visit, intensive preparations were made. Important people at the site, who had been identified during the preliminary site visit, were contacted by telephone and appointments were made for visits the next week. Staff thoroughly reviewed the Illinois statute and case law and identified questions of particular theoretic or practical concern for the Chicago system. Interview guides were mailed to people who were to be interviewed so that they could review the areas of concern in advance and prepare for the interviews if they wished to.

Three major activities were undertaken during site visits: interviews, observations, and staff discussions. Most participants were interviewed individually, although some were interviewed in groups. With very few exceptions, all interviews were done by two or three staff members. Before each interview, one staff person was assigned the role of "scribe." While the other person attended carefully to substance and led the interview, the scribe's duty was to record all answers. In this manner, one person could attend carefully to what was being said and be sure to investigate thoroughly all important questions; and the other person could be sure that everything that was said was carefully recorded.

All court hearings conducted during the time of the visit were observed. In Chicago, this included hearings at Read Hospital and at the Illinois State Psychiatric Institute. For each site, an observation guide was prepared and studied in advance of the hearings. (The observation guide for Chicago is included in Appendix C.) Staff took notes during the hearings.

Notes taken during interviews and court hearings were in rough and "scribbled" form. Each staff person rewrote the notes during the week following the site visit.

The third major activity--discussion and analysis--took place at the end of each day, when staff met to compare notes and impressions about the system. Key concerns were (1) what answers from various sources agreed with each other; (2) what answers from various sources disagreed; and (3) what answers still were missing. On the basis of these discussions, interview assignments for the next day were planned. When staff members were confident of the answers they had received, no further questions were asked on certain topics. When they were uncertain, additional attention was given to these questions in the next interviews.

The people who were interviewed in Chicago are listed in Chapter I. The site visit began with interviews with judges and observations of hearings. The next interviews tended to be with attorneys: assistant

state's attorney, private attorneys, and public defenders. Middle and later interviews tended to focus more on the mental health community: hospital administrators, mental health professionals, and patient advocates.

The people with whom interviews were held were not a statistically representative sample in any sense. They were chosen because they were identified as the most well-informed and influential people in Chicago with regard to civil commitment. This was consistent with the project goals: not to establish what is average or typical, or what the typical person thinks about the process, but to gain insight into how the system works and how it might be made better, from the perspectives of people with extraordinary and authoritative abilities to understand and comment on it.

The Form of the Data

The ultimate goal for this research project was to generate information through which the civil commitment process could be made to function as well as possible. The purpose of the data collection was to obtain practitioners' opinions, advice, and suggestions about the civil commitment process, particularly as it operates in their own localities. Accordingly, it was appropriate that the research be qualitative, not quantitative. Our main purpose was not to ask how many, or even how. The purpose was rather to ask why, how well, and how else. We sought information about what works best and why.

The questions in the data collection guide were open-ended. Multiple-choice types of question were avoided so that interviewees would be free to formulate their own opinions rather than have their thoughts slotted into predetermined categories by the researchers.

The data collection guide (in Appendix C) is a complete set of all the questions that were investigated. The interview guide covers many topics. The complete data collection flows in a more-or-less chronological order, as events occur during a typical commitment process. The questions unavoidably overlap to some degree, but repetition was minimized as much as possible. It should be easy to see that the interview questionnaire was organized in the same basic scheme that was used for the statutory analysis.

Because of the length of the data collection guide, every question was not asked of every interviewee. A subset of questions was presented in each interview to optimize the match of peoples' areas of knowledge with the questions asked. All interviewees were invited, however, to discuss any aspect of the commitment process with which they were familiar or about which they had particular opinions or suggestions. Interviewers were able to (and frequently did) stray from the planned path of questions if it seemed useful and appropriate.

The questionnaire was considered only a data collection guide, not a dictum. Precise language in the questions was not important, and neither was the order in which questions were covered. The guide was simply a reminder of important issues and ideas that needed to be discussed. More concern was given to understanding the answers than to writing them down thoroughly or verbatim.

A complete set of field notes, with all names and personal identifiers removed, is available from the National Center for State Courts. It will be provided upon request for the cost of duplication and mailing.

Analysis, Report, and Review

A qualitative content analysis was performed on the data. Interview and observation notes first were reviewed and cross-referenced. Note was made of topics of significance, points of consistent agreement, and points of disagreement.

The statutory analysis scheme was used as a general guide for the analysis of the site's civil commitment system. For each topic of concern, the analysis covered the statutory provisions, the actual practice at the site, and commentary about statute and practice.

Three major criteria were used to evaluate the civil commitment system in this report: legal protections, provision for treatment, and social benefits. The judgments of how to apply these criteria to elements of law and practice fell to these researchers, based upon their knowledge of the literature, observations, and discussions with practitioners. The reader is free, of course, to disagree with this analysis and may choose to view the system's strengths and weaknesses differently. As will be pointed out again later, a system characteristic may be simultaneously a strength and a weakness, when viewed from different perspectives.

First among the criteria, concern was given to the extent to which legal protections are provided to everyone in the system. The primary consideration was, of course, with the respondent. But statutes and procedures also can provide important legal protections to other people who become involved, such as doctors, attorneys, and members of respondent's family. Generally, this is an important criterion for those who are most concerned about respondent's liberty; but legal protections encompass more than simply protecting respondent from unnecessary hospitalization (e.g., protecting the right to treatment).

The analysis also considered how well a system makes provisions for treatment. Admittedly, we are assuming that a valid need for treatment does exist for at least some people some of the time. Provisions for treatment should be understood to encompass more than involuntary hospitalization, however; a system might get high marks in this regard by its creative consideration of less restrictive treatment alternatives and the opportunities for voluntary treatment that it provides.

Finally, social benefits were considered. Society in general has a legitimate concern with keeping each of its members safe from harm and contributing productively to the community. Society also is served by minimizing the costs inherent in a civil commitment system and eliminating any unnecessary delays in legal and medical decisionmaking.

These three factors are referred to in each of the following chapters in evaluating how well the system works. The factors are considered equally important in this report, and it is recognized that some system characteristics that score high in one area necessarily will score low in another. It should be noted, too, that we make no claim that this evaluative scheme is either unique or original. Professional literature reveals that these criteria are used commonly in considering commitment systems, as well as by judges in deciding individual commitment cases. The courts are accustomed to the approach of balancing (sometimes conflicting) interests as an approach to analyzing legal problems.

To complete the analysis, possible ways to change and improve the system were considered. These were written into recommendations at the end of each chapter and summarized in Chapter II. As explained in Chapter II, a three-point rating, reflecting both the theoretical importance of the recommendation and the potential difficulty in its implementation, was assigned to each recommendation.

The recommendations should not be taken as research conclusions or empirically proven statements of fact. Rather, they are the suggestions of these researchers, based upon our studies and points of view. As explained in Chapter II, the recommendations derive from a variety of sources: suggestions made by people in Chicago; suggestions made by people in other cities; conclusions from the professional literature; and ideas generated by these researchers during the project work. It is impossible to sort out the influence of these various sources in any recommendation, or to report accurately how extensive any person's or group's agreement would be with any single recommendation.

The purpose of presenting recommendations is to highlight certain problems and alert people in Chicago to possible solutions. Although it is easy for us to identify a problem, we are too far removed from the system to be expected to have "The Answer." A more realistic goal is to present "an answer," however modest and tentative, as a stimulus and starting point for thoughtful consideration by those who know Chicago's system better and are in a position to make appropriate changes.

Site reports were reviewed first by project staff and then sent out as "review drafts." The Chicago report was sent for review by all members of the Chicago advisory board and by all individuals who had participated in the data collection effort. Everyone receiving a review draft was invited to make suggestions for change and was urged to correct any statements that were factually incorrect. A meeting was held with the Chicago advisory board to review this draft as a group. Others who had participated in the data-collection effort also were invited to the meeting of the advisory board.

Reactions from these people were taken into account in preparing the final text. (Written comments received from this group are included in the raw data materials available from the National Center.) As a result of their comments, several portions of the text were corrected and modified and a number of the recommendations were altered. It should not be inferred, however, that this report or its recommendations have been adopted officially by the Chicago advisory group, or that the group had a unanimous concurrence of opinion on all the issues raised in this volume. The information in this report reliably generates energetic differences of opinion among readers. Thus, although the advisory group's comments were incorporated into this report, the text should not be taken as a consensual statement or endorsement from that group.

To finish the document, a National Center for State Courts editor provided a final stylistic edit. The document was then printed and distributed.

CHAPTER V. OVERVIEW OF THE CHICAGO SYSTEM FOR TREATING THE MENTALLY ILL

Purpose

This thumbnail sketch of the Chicago system will give the reader a general view without going into fine detail. (Those readers who are well acquainted with the Chicago system will find this material to be of relatively little value and probably can skip reading it with no loss of important information.) While the overview in this chapter is generally correct, it should be considered neither exact nor complete. Precision and completeness have admittedly been sacrificed for the sake of clarity and brevity.

The overview is a blend of both what is required by statute and what actually happens in practice. The implementation of the civil commitment law in Illinois, as in all other states, is not always what would be expected from a literal reading of statutes. While most statutory provisions are adhered to strictly, some are not. More important, the system has evolved procedures for working through problems and making decisions in situations that are not addressed specifically by statute.

The focus of this report is on how the system operates in reality. Reference will be made throughout the report to how the system should operate (according to statute) and how it otherwise might operate (according to recommendations). But the starting point of this analysis will always be with what is actually happening in the system, for this is the reality with which judges and other concerned professionals must cope.

Many differences of opinion arise over statutes and their implementation with regard to civil commitment of the mentally ill. It is admittedly fascinating, but it is not sufficient, merely to catalogue these differences in opinion. This chapter ends with a short discussion of some of the reasons for these differences in opinion.

Overview of the System

The Chicago system for treating the mentally ill is shown schematically in the figure on the following page, and our discussion will supplement the information there presented. The process begins when a person exhibits what appears to be a mental health problem. Of course, many people have mental health problems to greater or lesser degrees and never seek any type of formal treatment. They, and others who come into contact with them, simply cope with whatever difficulties this may create. If treatment is sought, the mentally ill person might come into contact with a community mental health treatment facility or may be brought to a hospital.

STAGE 1. PERSON HAS A MENTAL HEALTH PROBLEM

A. Person pursues community outpatient treatment (Go to 2.1)
B. Person requests hospital treatment (Go to 2.2)
C. Others initiate action for involuntary treatment (Go to 2.3)
D. No treatment sought; everybody copes (END)

STAGE 2. EFFORTS ARE MADE TO INITIATE (OR CONTINUE) TREATMENT AS . . .

2.1 COMMUNITY OUTPATIENT TREATMENT

A. Person receives treatment (Go to 7)
B. Person referred to hospital as voluntary patient (Go to 2.2)
C. Person referred to hospital involuntarily (Go to 2.3)

2.2 VOLUNTARY HOSPITALIZATION

A. Hospital admits and treats as "informal" (Go to 6)
B. Hospital admits and treats as involuntary (Go to 6)
C. Hospital refuses to admit; patient may appeal (Go to 1)

2.3 INVOLUNTARY TREATMENT

A. Police or State's Attorney divert case (Go to 1)
B. Person decides to seek voluntary treatment; case dismissed (Go to 2.1 or 2.2)
C. Person remains at home; CMHC examines and does not certify; case dismissed (END)
D. Persons remains at home; CMHC examines and certifies for hearing (Go to 3)
E. Hospital examines and releases (END)
F. Hospital examines and certifies for hearing (Go to 3)

STAGE 3. A COURT HEARING IS SCHEDULED

A. Symptoms remit, person discharged, case dismissed (END)
B. "Technicalities" arise; case is continued (Stay at 3) or dismissed (END)
C. Hearing takes place (Go to 4)

STAGE 4. A COURT HEARING IS HELD

A. Judge dismisses case; person discharged (END)
B. Judge commits to hospital for treatment (Go to 5.1)
C. Judge commits to alternative treatment (Go to 5.2)

STAGE 5. PERSON IS UNDER LEGAL ORDER TO RECEIVE TREATMENT. . .

5.1 IN A HOSPITAL

A. Treatment status continues for statutory interval; symptoms remit (Go to 7) or continue (Go to 2.3)
B. Treatment until hospital wishes to discharge patient (Go to 6.1)
C. Treatment until patient wants to be discharged (Go to 6.2 or 6.3)

5.2 IN A LESS RESTRICTIVE MANNER

A. Treatment status continues for statutory period; symptoms remit (Go to 7) or continue (Go to 2.3)
B. Treatment director or court decides hospitalization is required (Go to 3)
C. Patient wants to be discharged from treatment (Go to 6.3)

STAGE 6. TERMINATION OF TREATMENT IS SOUGHT

6.1 BY THE HOSPITAL

A. Patient is discharged (Go to 7)
B. Patient resists discharge by successful appeal to Utilization Review Committee or court (Go to 5.1)

6.2 BY A VOLUNTARY PATIENT

A. Hospital discharges patient (Go to 7)
B. Hospital initiates petition for involuntary treatment (Go to 3)
C. Patient escapes (Go to 7)

6.3 BY AN INVOLUNTARY PATIENT

A. Treating facility discharges (Go to 7)
B. Patient appeals commitment decision (Go to 3)
C. Patient brings habeas writ (Go to 3)
D. Patient files petition for discharge (Go to 3)
E. Patient escapes (Go to 5.1 A. or 5.2 A. or 7)

STAGE 7. PATIENT IS DISCHARGED FROM TREATMENT

A. No further problems (END)
B. Person recidivates (Go to 1)

Many people receive treatment for mental health problems through Chicago's excellent system of community mental health centers (CMHCs). If the person's condition is such that the the CMHC cannot provide effective treatment, however, the person may then be brought into contact, either voluntarily or involuntarily, with a hospital (Stage 2).

The majority of persons who receive hospital care for mental health problems enter the hospital voluntarily. Voluntary patients can enter a hospital as "informal" patients (frequently done in private institutions) just as they would enter a hospital for the treatment of any physical ailment. Informal patients are free to leave the hospital at any time. Or, patients may enter a hospital as "voluntary" patients (as is usually done in the public (state) hospitals), which places them under slightly more control by the hospital. Hospitals are not obligated to accept patients who wish to be admitted for the treatment of mental problems; but patients who are refused admission have a right to appeal this decision to an administrative committee at the hospital.

The major concern for this report is with people who face the possibility of becoming patients in a hospital, but not by their own volition (Stage 2.3). Frequently, when attempts are made to hospitalize a person against his or her will, the person may then elect to seek admission on a voluntary basis. In such cases, efforts to hospitalize the person involuntarily are usually (but not always) terminated and the person enters the hospital voluntarily.

Bringing a person into hospitalization against his or her choice usually necessitates the involvement of state officials: the police and/or the assistant state's attorney. These officials will evaluate the circumstances informally and take one of two courses of action. They may divert the case from any further formal involvement and send all concerned individuals back home (perhaps with a referral to a CMHC). Or, they may decide to take the next steps that will lead to an evaluation of the person's mental health problem by a professional examiner.

If the mentally ill person is in need of immediate hospitalization in order to protect his or her physical well-being or that of others, the person will be taken to a hospital, usually by the police, for an immediate examination. Much less frequently, the person will not need immediate hospitalization and will be able to remain at home until he or she is to report to a facility (such as a CMHC) for a mental health examination. In either case, the results of the examination will determine whether the person is immediately released, and the case dismissed, or whether a judicial hearing will be scheduled to determine whether or not the person is to be ordered into treatment.

Generally, no more than a week passes from the time that an involuntary action is initiated against a person until the time that a hearing takes place (Stage 4). Within that time period, the symptoms of the mental health problem may remit, the person will be discharged from the hospital (if hospitalized), and the case will be dismissed

summarily. Sometimes, legal technicalities occur that complicate or delay the case. For example, a petition may not contain all the required information or a medical certificate may be filed at a time that is past the statutorily prescribed deadline. Because of these legal difficulties, the judge may dismiss the case outright, or may continue the case to a later date to allow time for the technical errors to be corrected.

For people who continue to exhibit mental health problems and for whom all necessary steps toward commitment have been taken in a legally sufficient manner, a court hearing is held on the merits of the case. Most hearings are held in one of two hospitals in the city. In rare circumstances (e.g., a jury hearing has been requested) they are held in regular courtrooms downtown. With few exceptions, respondents attend the hearings, where they are represented by a public defender. An assistant state's attorney presents the case for the state.

As a result of the hearing, the judge must decide whether or not this person is one who is "subject to involuntary admission." If the judge decides the person is not subject to involuntary admission, the person is immediately discharged. If the judge finds the person subject to involuntary admission, he or she may order treatment within either a hospital or an alternative treatment setting (Stage 5), although the former is much more frequent than the latter.

For people who are seriously mentally ill, few alternatives to hospitalization are available. One option is for the judge to order a patient into the care and custody of a family member, if the family member is willing and able to provide for the patient's treatment needs. Treatment in a less restrictive mode, such as care and custody or through an outpatient clinic, will continue as ordered by the judge until either the statutorily prescribed commitment period ends, the symptoms remit, or an attempt is made to change the patient's status (Stage 5.2). During the course of treatment, it might be decided that the patient requires hospitalization after all, and a court hearing will be scheduled to determine whether or not hospitalization should be ordered. Or, the patient may petition the court for discharge from the treatment order on the grounds that he or she is no longer subject to involuntary admission.

When a person is judged to be subject to involuntary admission, he or she usually is admitted to a hospital inpatient facility. Admission is almost always to a public (state) hospital, although a patient can be ordered to a private hospital, if the hospital is willing to accept the patient. Treatment is made available to the patient for up to the statutorily prescribed time interval, at the end of which either the patient is discharged or the hospital initiates the process leading to a hearing on the question of retaining the patient. If the patient's symptoms remit, of course, the patient will be discharged immediately. The hospital may discharge the patient at any time, although the patient may appeal a discharge to the hospital's administrative committee. Also, any patient who believes he or she is ready for discharge may petition the court for a hearing on this question.

Patients who have entered the hospital voluntarily may request a discharge at any time (Stage 6.2). The hospital has no authority to retain any "informal" patient once a request for discharge is made. The hospital may retain a "voluntary" patient, however, for a period of up to five days, during which time it may initiate actions seeking the patient's hospitalization on involuntary status. Of course, voluntary patients occasionally simply leave the hospital without authorization (i.e., they escape); such patients usually are discharged officially from the hospital if they are not apprehended or do not return voluntarily within a short interval of time.

Patients whom hospitals continue to treat on an involuntary basis may seek their release in several ways. For example, patients have the right to appeal the original commitment decision, although this is an infrequent event. As mentioned above, a patient may file a petition for discharge, which will guarantee a judicial hearing on the question of whether or not he or she still meets the criteria of being subject to involuntary admission. Patients also may file a writ of habeas corpus, which, if granted, will also result in a judicial hearing. Not infrequently, another manner by which involuntary patients terminate their relationships with the hospital is through escape; such patients are retained "on the books" in the status of "unauthorized absence" until the completion of the commitment period.

If a patient's condition does not improve, he or she can remain in the hospital for up to 60 days. The patient must then be discharged unless the hospital petitions for another 60-day commitment order. This recertification period (and all subsequent periods, which may each be up to 180 days) requires a judicial hearing exactly like the initial commitment hearing.

Patients who are discharged from hospitals leave with a small supply of medication and information on how to contact community mental health agencies, as needed. If mental health problems arise again, which unfortunately is the case for many former patients, the entire process is begun anew.

The Question of Attitudes

It is impossible to consider the system for the involuntary treatment of the mentally ill without getting caught up in differences of opinion and conflicting attitudes about mental illness and society's proper response and responsibility. A mental health system will be appreciated to the extent that it can accomplish two fundamental objectives. Some people value a system that can provide easily for the treatment of mentally ill individuals because of the obvious need and society's responsibility to respond to the need, even if treatment must be coerced. Other people, though, value a mental health system to the extent that it can protect individuals from hospitalization or treatment being thrust upon them involuntarily. For ease of future reference, we will refer to the first of these perspectives as the "helping attitude" and the second of these as the "liberty attitude."

This report will attempt to represent the helping attitude and the liberty attitude in equal strength. It is safe to say, however, that most people tend to favor one or the other more strongly. Equally true, the attitude that prevails is influenced strongly by the circumstances inherent in any particular mental health case.

Some people hold these attitudes in the extreme. Those who are strongly biased toward the helping attitude may contend that mental illness is, per se, sufficient reason to treat an individual against his or her will because that person's capacity for voluntary and intelligent decisionmaking is necessarily impaired. This is not to say that people who subscribe firmly to the helping attitude propound the absolution of all rights, however. They may maintain a strong orientation toward respecting patients, minimizing unnecessary restrictions, providing humane and adequate care, and so on. On the other extreme, those who hold the liberty attitude may contend that mental illness really does not exist. They view people as having wide ranges of behavior to which society must accommodate without interference. Such people, however, agree that behavior harmful to others is obviously, cause for concern; but they argue it should be handled through the criminal, rather than the civil, justice system.)

Try as one may to balance the helping atttitude and the liberty attitude, many situations arise in civil commitment procedures that bring these two attitudes into sharp conflict. While the objectives of helping people and protecting freedom are not necessarily contradictory, decision points arise where the two attitudes may compel contradictory ways to proceed. Differences in opinion about what decisions may be "good" or "bad," "right" or "wrong," stem from a fundamental disagreement about system objectives as seen in the context of the two contrasting points of view discussed here.

As an example, suppose that a medical certificate supporting the commitment of a respondent is filed with the court 12 hours later than required by the statute. What should the judge do? A judge may dismiss the case because the hospital did not follow the letter of the law. Or, the judge may order the patient's continued retention in a hospital, despite the "legal technicalities," in order that the patient can continue to be considered for treatment. The action that is considered "right" for the judge depends upon whether one has a stronger attitude toward helping a person or protecting a person's liberty interests.

Disagreements about the value of a civil commitment system frequently can be understood by nothing more than reference to these differing attitudinal perspectives. The best system will find ways to accommodate both interests; but conflicts between them are admittedly impossible to avoid and occasionally will force a choice between one or the other.

CHAPTER VI. PREHEARING

Description

This chapter considers the various ways in which a person may enter the mental health system in Chicago. Attention is exclusively with actions and events prior to a formal hearing. For many people, of course, the prehearing process constitutes their total involvement with the involuntary civil commitment process. That is, a majority of those entering the Chicago system will not be admitted by the hospital, will enter the hospital on a voluntary basis, or will be admitted and subsequently discharged before a hearing is held.

A. INITIATING MENTAL HEALTH TREATMENT

Mental health care that is to be the focus of this report is primarily care provided by hospitals through their inpatient facilities. To understand mental health treatment in Chicago, however, one must appreciate the enormous service performed by the community mental health centers (CMHCs) operated by the city and other private concerns. This network of CMHCs treats Chicagoans who have relatively mild mental health problems, provides them all the services they need on an outpatient basis, and probably prevents a vast number of them from becoming seriously ill enough to require inpatient hospitalization. As a result of these extensive community services, and buttressed by a commitment statute that sets a rigid criterion for involuntary treatment, those people for whom judicial commitment becomes a possibility are almost always serious mental health cases. This is a major reason why most commitments are to hospital inpatient facilities.

This characteristic of the Chicago system is at the same time something to be remembered and something to be kept in perspective. Knowing that people who are the subjects of commitment hearings usually are seriously ill helps one understand and appreciate the way Chicago's commitment system works. Assuming that <u>any person</u> who comes into the system is seriously ill, however, may be a grave error. Because the system works as it does, the potential is great to assume erroneously that just because a respondent is having a hearing, he or she <u>must be</u> in need of help. Even though the CMHCs effectively screen out most of the less serious cases, the challenge to the judicial system is to evaluate carefully the cases that come before them, free of any unwarranted predispositions toward commitment. This point will be raised again in a later chapter with regard to commitment to the least restrictive alternative.

The largest proportion of people receiving inpatient treatment in Chicago have entered the hospital on a voluntary basis. The Illinois statute makes it possible for people to enter a hospital either as an "informal" patient or as a "voluntary" patient. The Illinois statute (3-300) provides that a patient on informal status retains the right to be discharged immediately upon request at any time during normal working hours. The statute also indicates that any person (or "any interested

person . . . at his request") may apply for admission on a voluntary status (3-400, 3-401). If the hospital admits the patient on voluntary status, it retains the right to hold the patient for five days after patient has requested discharge, during which time it may initiate an action to retain the patient on an involuntary basis (3-403). Further, if a patient is admitted on a voluntary status, the patient's record is to explain why an informal admission was not suitable. For the most part, informal admissions are used extensively at private hospitals in the Chicago area while voluntary admissions are used almost to the exclusion of informal admissions in the public hospitals.

A small proportion of the involuntary commitments begin when respondents arrive at a hospital or mental health center accompanied by family members or other concerned people. After going through a psychiatric examination, the respondent may prefer to go home but the psychiatrist may decide the person is in need of hospitalization. The psychiatrist, or more frequently one of the people who accompanied the respondent to the mental health facility, then initiates a petition and medical certificate and the patient is admitted to the hospital. (In this report, the person who signs the petition and thereby initiates a formal action of involuntary commitment is referred to as the "petitioner.") If the psychiatric examination took place in an outpatient facility, the police are called and requested to transport the patient to a hospital.

The Chicago police willingly provide emergency transportation service for involuntary mental health cases; but the circumstances and manner of transportation vary greatly depending upon individual officers, the time of day, the police workload at that particular time, the particular place within the city, and other factors. Under the most favorable circumstances, police respond promptly to a call for help in transporting a mental health case. If the call was placed by a psychiatrist at a community mental health facility, the police usually transport the respondent from the community facility to a public (but not to a private) hospital. If the call to the police was placed by a family member or concerned citizen, the police do not necessarily respond to the call nor, if they do appear, necessarily transport respondent to a hospital. When the call to the police does not sound like a dire emergency, the police frequently direct the caller to contact the state's attorney to obtain a court writ authorizing the respondent's detention. For those cases in which the police respond to the call, they decide, on the basis of their own observations, whether the respondent's behavior warrants treatment through the mental health system, the criminal justice system, or some informal diversion. If the police decide that the person should be taken for examination at a hospital, they attempt to have the person who made the initial call act as petitioner in the case rather than assuming that responsibility themselves.

Concerned family members or other citizens, referred by the police or by others, may bring a respondent's case to the attention of the state's attorney, who reviews the case with the complainant and decides whether or not it is appropriate for the mental health system.

If the state's attorney does not divert the case at this point, he has the complainant initiate a petition and then takes the case before a judge, who then may issue a writ to authorize respondent's detention. The police then are notified to take respondent into custody and transport him or her to a hospital for examination. The police provide this transportation for all cases in which it is requested by the state's attorney and authorized by judicial writ.

The police also can become involved by witnessing aberrant behaviors and initiating a mental health commitment on their own (3-606). Police on the beat may witness behaviors that they think indicate a mental health problem. In these cases, the police may take respondents into custody and bring them directly to mental health facilities (usually an inpatient facility, but sometimes an outpatient clinic).

When respondents are transported to a mental health examination by the police, they are considered to be in "protective custody." The police have negotiated a "no decline agreement" with several hospitals in the Chicago area, meaning that the hospitals have agreed not to refuse summarily to examine patients brought to them in this manner. If the respondent has engaged in a criminal misdemeanor, an officer may take respondent for a mental health evaluation and await the hospital's decision of whether or not to admit. If the hospital decides to admit, the police do not pursue the misdemeanor charges. If criminal behavior of a felony nature is involved, the respondent always is taken directly for an appearance before a judge; mental health treatment, if indicated, then occurs by means of the criminal justice system (most frequently at the Cook County Jail).

Mental health treatment also may be initiated at the instigation of a judge. The Illinois statute (3-607) allows a judge the option of initiating a petition based upon the judge's observations of respondent in court. According to the 1976 Governor's Report, the intent of this statutory provision was to enable a judge to initiate mental treatment for a person who might require immediate admission during the judicial process. Further, it was to allow a criminal court the ability to have a person treated by the mental health facilities rather than keeping him in a jail. It has been alleged by some attorneys, however, that this provision in the statute is used in another way that probably was not intended. It is said that in civil cases that fail to meet all statutory requirements (such as incomplete information in a petition or certificate) and that force the judge to dismiss a case, the judge can use this provision of the law immediately to initiate a new commitment proceeding. In this way, the judge can continue to keep respondent in custody if he or she feels that the respondent needs hospitalization, based upon observations in the court.

For the sake of completeness, it should be noted that a small number of civil commitment patients have been transferred from the criminal system. These are special cases to which no further attention will be given in this report.

All of the involuntary admissions referred to above are authorized by the Illinois statute as "emergency" admissions. In all of these, it is alleged not only that the person is subject to involuntary admission but also that he or she is in need of immediate hospitalization.

The statute also provides for admission to a hospital in a situation that is not an emergency (see generally, Article VII of the statute), although this procedure is practically never used. A petition can be filed with the court seeking involuntary treatment for respondent, who is allowed to stay at home pending a mental health examination. After determining that there is probable cause to proceed with the case (3-701), the judge can then order respondent to report for a mental health examination (3-704), preferably at a community mental health center. If the person is so ordered and does not comply, police then may be authorized by judicial writ to detain the respondent and bring him or her to the appropriate facility for the examination. Following the examination, the person's case can be dismissed if the examiner feels he or she is not in need of mental health treatment, as defined by statute. If treatment is indicated, however, the person can be immediately hospitalized if that is warranted, or can be allowed to return home to await the judicial hearing. If a person who has returned home pending hearing fails to report for the hearing, the judge may issue an order for the person to be taken into custody and brought to the court for a hearing (3-706). As noted above, people in Chicago who need mental health care that does not require inpatient treatment can easily receive such care through the CMHCs. And, if people meet the statutory requirement for involuntary commitment, their cases are usually so severe that immediate hospitalization is required. Thus, the statutory provision for commitment proceedings without prehearing detention is rarely used.

B. PETITIONS AND CERTIFICATES

The Illinois statute calls for the filing of a petition and two certificates to initiate a commitment proceeding (3-601, 3-602, 3-603, 3-701, 3-702, 3-703). The petition serves, in effect, as an allegation by one person (petitioner) that another person (respondent) is in need of mental treatment. The certificates are statements filed by qualified examiners (who may be social workers, nurses, physicians, psychiatrists, or psychologists) in support of petitioner's contention (1-122, 3-602, 3-702). Statute requires that the two certificates be filed independently and that at least one must be completed by a psychiatrist. For an emergency commitment, which most Chicago commitments are, the second examiner must always be a psychiatrist.

Petitions and medical certificates tend to be filed as required. People in the Chicago system disagree, however, about the quality of the information filed in these documents and the consequences of having deficiencies in them. Hospital staff tend to report that when the petitions and certificates are deficient in some way the judges tend to dismiss the cases, thereby frustrating attempts to give treatment to people who need it. The public defenders and other attorneys, on the

other hand, agree that these documents occasionally have legal deficiencies. But they are more likely to report that judges usually overlook such deficiencies, continue to hold the respondent in custody, and hear the case on its merits, which, in their opinion, thereby deprives the respondent of his statutory legal protections. From a legal point of view, the petition is a collection of allegations needed to establish no more than a "probable cause" to believe that the respondent is in need of mental health treatment. Judges who may appear to hold more to the "helping" attitude (see last section of Chapter V) tend to see the substance of the petition as more important than its form and tend to hold a respondent in this circumstance, whereas judges with more of the "liberty" attitude give greater emphasis to the protection of the respondent's legal rights.

A number of people in Chicago agree that information provided on the petitions in some cases is overly general and overly reliant upon unsubstantiated opinions. The petition provides the initial factual basis for possible conclusions that the respondent is dangerous to self or others or is seriously unable to care for basic physical needs. Most professionals agree that although psychiatrists are certainly more accurate in detecting mental illness, these experts are no better than lay individuals in their conclusions about dangerousness or the ability to care for oneself. These conclusions can be made more accurately on the basis of reports about the respondent's behaviors "on the streets" than from results of an examination in a doctor's office. This was recognized in the 1976 Governor's Report, which commented "that it would be difficult to consistently and accurately apply the subjective evaluation of dangerousness or helplessness . . . without the support of an overt act or threat" (p. 16). Despite this conclusion, the current statute <u>does not require</u> that the petitioner report an overt act or threat. A commitment can proceed on the basis of lay opinion, expressed in a petition, without citing overt behaviors to support these conclusions.

Although attorneys have argued for requiring a report of an overt behavioral act, doctors are pleased that this is not a statutory requirement. Doctors observe that people may behave in ways that strongly suggest violence to themselves or others but that are not explicitly violent or threatening. They suggest, for example, that a man may speak about going to join his dead parents; or a man whose wife is deceased may talk cheerfully about re-uniting his children with their mother. While statements such as these are neither violent acts nor explicit threats, they can precede tragic acts of violence by people who are in a psychotic state. Empirical research suggests that the incidence of actual violent acts following such statements is small, and that is why attorneys prefer the overt act requirement; but doctors feel that the risk indicated by such statements is sufficiently great to justify initiating a commitment, and prefer that overt acts and threats not be required on petitions.

The allegations and shortcomings of the petitions reportedly may be repeated on the medical certificates. That is, information on the first medical certificate not infrequently repeats that which was written on the petition, and information on the second examiner's certificate not infrequently repeats information from the first certificate. The examiner's certificates ideally should present independently both facts and statements of opinion; but attorneys in Chicago report that certificates more commonly contain only statements of fact or statements of opinion and not both.

It is probably safe to say that in statutes across the country requiring more than a single examination of respondent, the intent is to have independent examinations. This is a legal protection against the possibility of malicious action by a single doctor as well as a way of overcoming the notorious unreliability of differential psychiatric diagnoses and opinions. Insofar as examiners have access to a respondent's previous psychiatric records, to the petition alleging mental illness, and to certificates (or file materials) from other examiners, psychiatric examinations and evaluations will not be independent but rather will be influenced strongly by the conclusions of other doctors who have seen the respondent previously. This frustrates the intention of the statute, though doctors (and many legal professionals) staunchly defend the sharing of psychiatric information as critically necessary to diagnosis and treatment.

Another problem that occurs with some certifications in Chicago is that they are difficult to read and understand because of language problems. Many foreign-born doctors work for the state health facilities in the Chicago area. While most foreign-born doctors are highly regarded, and while their medical qualifications are readily acknowledged, their written reports occasionally are hard to read and understand simply because of language deficiencies.

C. SCREENING MECHANISMS

In effect, screening of mental health cases prior to their entry into the judicial system is accomplished in three ways. As mentioned in the first part of this chapter, the community mental health centers provide services that meet the needs of a vast majority of people with mental health problems. Without this broad system of CMHCs, many of these cases might find their ways to the emergency rooms of the city's hospitals unnecessarily. The other two sources of screening, police officers and the state's attorney, are involved with the majority of cases that come into the formal system. Those familiar with the work of the police and the state's attorneys office all seem to feel that these people do an effective and conscientious job of diverting cases away from the judicial system when other alternatives for handling these cases are more appropriate.

On paper, the only screening mechanisms in this system are the reviews of petitions and the filing of medical certificates. If a facility director or judge does not find reasonable cause to believe the allegations of the petition, the petition will not be accepted and the respondent will not be taken into custody. Similarly, if either of the two examiners concludes that the respondent is not subject to involuntary admission according to statutory criteria, the respondent is immediately released. These screenings help ensure that only serious cases reach the stage of a full judicial review.

D. PREHEARING DETENTION

The statute allows for a period of up to five days from the time respondent is taken into custody until a judicial hearing must be held on the case (3-611). (Note that this holding period is five court or working days, because Saturdays, Sundays, and holidays are specifically excluded from the number of allowable days. For purposes of brevity, this will consistently be referred to as a five-day period and the Saturday, Sunday, and holiday exception will not be noted in the remainder of the report. With regard to this and other matters, the statute should always be consulted directly for an authoritative understanding of its provisions.) In practice, virtually all respondents receive their guaranteed hearing within the required five-day period, although many hearings result in continuances that delay final dispositions (for reasons to be discussed below).

It is widely agreed that the five-day period represents a good balance between minimizing the amount of time a person must be held without hearing and maximizing the acquisition of information and preparation necessary for a meaningful judicial hearing. The five-day period seems to be most constraining for the public defenders, who find it difficult to prepare their cases adequately and completely in this amount of time. It is especially hard, they report, to arrange for witnesses on respondent's behalf who will testify at the hearings within this short time interval. Mental health staff apparently have no difficulty in examining patients and preparing their necessary reports within the allowed time.

If a patient has been taken into custody and an examiner who is to prepare a certification determines that the person does not meet the statutory criteria, the person will be discharged immediately. Further, some patients are examined and certified but improve sufficiently to be released from the hospital during the five-day period prior to a hearing. All such patients are discharged as soon as their conditions warrant and their cases are routinely dismissed when they come before the court. It was reported to these researchers that some doctors hold respondents in the hospital as long as possible and discharge them just prior to their scheduled hearings as a way of dispensing treatment yet avoiding cases that are likely to be weak in court. While this practice can be viewed as an abuse of the system, it is one of low frequency. The respondent in such a case is enough in need of help that he or she has been certified by two examiners, and he or she could be held only for about four days in any event.

Some attorneys and advocates have proposed that patients who are discharged prior to a judicial hearing might want their "day in court." Yet, in Chicago (as well as in interviews across the country), it has been reported without fail that respondents all want their cases summarily dismissed and show no inclination to take the case to court in order to clear their names, set the records straight, make a philosophical or legal point, or pursue any other such goal.

The Illinois statute is unique in its careful provisions for avoiding detention prior to examination and judicial hearing in matters of civil commitment (3-704(a)). For all intents and purposes, however, this statutory provision is all but unused. It is good in theory and there is certainly no reason to alter the statutory provision, but its impact on the system in a practical sense is disappointingly minute. It is not hard to imagine, however, that this statutory provision might be more important, practically, in areas where hospital facilities were fewer and the need to hospitalize dangerous people were less.

E. NOTIFYING RESPONDENT OF RIGHTS

The two sources from which a respondent usually learns of his or her legal rights are the hospital and the attorney (usually the public defender). Because no criminal charges are involved, police do not inform respondent of legal rights when they take him or her into custody. The examiner, to whom the respondent is brought by police or others, is required to inform respondent of the purpose of the examination and of respondent's right to remain silent. If the hospital examiner certifies respondent for admission pending a judicial hearing, the respondent will be informed of additional rights, pursuant to the policy of the particular hospital and the requirements of the Illinois statute. (Examples of forms provided by the hospitals to inform patients about their rights may be found in Appendix B.) Attorneys who are assigned to represent these cases generally will repeat these rights to the respondents during their first meeting.

An explanation of the patient's rights is related to, but not perfectly congruent with, an explanation of the process that the patient is about to experience. Public defenders express the opinion that respondents often are not informed adequately about the civil commitment and hospitalization process. They report that many respondents they meet with in the hospital do not understand what is happening to them in the hospital, what is going to happen to them during the prehearing and hearing procedures, how they can request various types of assistance, how they can request release from the hospital, and so forth.

While it appears that all respondents receive information about their legal rights and the civil commitment process, many questions are raised about the efficacy of this procedure for the respondent. Mental health staff frequently consider such communications to be a waste of time, believing that respondents are mostly too ill, anxious, and generally confused to have a good comprehension of the rights and process

about which they are being informed. Overwhelming such people with confusing papers and verbal gibberish merely exacerbates an already strained situation, they say. Furthermore, the impression that attorneys have when giving information to their clients at a hospital (i.e., that the patient has never heard this information before) can also be attributed to the possibility that patients heard it but were unable to understand it or remember it. Indeed, it is possible that the information presented (for a second time) by the attorney makes no more lasting impression than that provided by the hospital staff. While attorneys and judges seem to be reassured merely by seeing that the information is transmitted to these people, they will admit that the language and concepts on the legal rights statements are complex and probably would confuse most people about whose mental health there would be no question. Lay individuals who are concerned with the mentally ill merely point out that, for whatever reasons, few respondents really understand their legal rights or how to make use of them, and suggest that more individual and thoughtful counseling with each respondent is necessary and would be of value. Confirming this impression of the respondents' confusion, public defenders report that their clients often think the public defenders are part of the hospital staff and that many seem to resist (or at least do not cooperate with) counsel's assistance as a result.

To a smaller degree, charges have been made that respondents are not provided services and privileges to which they are entitled. For example, although the statute ensures patients the right to communicate with others by telephone, some patients have access only to pay telephones and do not have the money with which to pay for telephone calls. It also has been alleged that in some facilities, seclusion and restraints are used in a punitive manner and that patients are not provided adequate protection for personal belongings. These researchers have no first-hand information by which to confirm or deny these allegations. The most important point is that respondents need to be informed clearly about what their rights are, including their rights to obtain legal help if and when these rights are violated.

F. OPPORTUNITY FOR VOLUNTARY ADMISSION

The opportunity for voluntary admission to mental health treatment becomes important within two different contexts: first, independent of the involvement of police, state's attorney, or the court, a person (or others on behalf of the person) may apply for admission to a treatment facility; or second, following the preparation of a petition for commitment, a respondent (or others on respondent's behalf) may apply for admission at any time up to the adjudication of the case (3-801). In either circumstance, the person may request either an informal admission or a voluntary admission (3-300, 3-801). If a person applies for informal admission and is admitted instead as a voluntary patient, an indication must be made in the patient's record as to why the informal status was not allowed (3-300(c)). Only in the first instance (with no pending petition), if voluntary admission is denied, respondents must be informed of their right for a review of this decision by an administrative hospital committee (3-405).

Issues surrounding voluntary admissions when no petition is pending are discussed in Chapter XI. The most important of these is the use of voluntary rather than informal status. Another issue is that apparently hospitals deny many requests for voluntary admissions and virtually none of these denials is contested. Building upon those discussions in Chapter XI, further consideration is given to voluntary applications made when a petition is pending, which is the situation addressed in the remainder of this section.

Note that the statute gives respondent only the right to apply for admission; this is not an automatic right to admission. The facility director can accept or deny the application. Even if a facility director accepts a respondent's application for voluntary admission, the statute allows the judge to consider whether such admission would be in the best interests of respondent and the public (3-801). A judge can deny a respondent's application for voluntary admission and continue to hear the case for involuntary commitment. This important element of the Illinois statute makes it possible to prevent patients from abusing the voluntary application privilege by using it merely as a vehicle for obtaining release within a five-day period.

When an involuntary proceeding has begun, the state's attorney also can object to the patient's admission as a voluntary patient. This will result in a judicial hearing on the allowability of voluntary admission. If the judge approves of the voluntary admission, the patient enters the hospital and the involuntary commitment case is dismissed. If the judge disapproves, a hearing on the involuntary commitment is held in the usual manner.

Chicago judges have been concerned about possible abuse of voluntary admissions by mental health staff. By having a patient enter voluntarily rather than through judicial commitment, the treatment facility avoids much paper work and staff time required by the civil commitment process. This raises the fear that respondents may be pressured into making "voluntary" applications. Statutory language (3-402) shows a clear concern that patients not be coerced into seeking voluntary admission to a facility. Recently, a court rule has been introduced that requires counsel to certify that a patient who has requested voluntary admission did so willingly and with full understanding of the consequences of his or her action. Through this process, judges are assured by the attorneys that patients are not being talked into treatment against their wishes and without a court hearing. In some cases, judges may still require the patient to come to court so the judges can be personally satisfied that the application for voluntary admission was made willingly.

Following commitment, patients may request a change to voluntary status, which must be approved by the treatment facility director. At the end of a patient's authorized period of involuntary treatment, if the facility director intends to petition for an additonal period of commitment, the patient must be given notice at that time of the right to apply for voluntary admission (3-902(b)).

G. PREHEARING EXAMINATION

As discussed above (Section B), two examinations are required to retain a respondent in custody and bring the issue to a formal judicial hearing. The statute anticipates that the first examination will take place at or before the time that a petition is prepared and a respondent is taken into custody. In any event, an examination by a psychiatrist (whether it is the first or the second examination) must be performed within 24 hours of the time that a respondent is admitted to a mental health facility. In practice, respondents almost always receive both examinations within a 24-hour period following their admission to a mental health facility, and no one ever is held for a period of time greater than 24 hours without at least one examination's having been performed. Certificates of examination are filed promptly with the court and hearings are scheduled promptly as well.

Illinois statute allows the respondent to request an independent examination (3-804). In practice, however, independent examinations rarely occur. Neither the statute nor practice has established a mechanism for funding independent examinations. Also, requesting an independent examination usually means that a hearing will be delayed at least one week, which has been a disincentive for respondents to request these examinations. Finally, the independent examiners are appointed by the judges (rather than being chosen by respondents) and have come from the staff of the State of Illinois's Department of Mental Health and Developmental Disabilities. Chicago attorneys feel that these examiners are not "independent," because they are affiliated with the regular hospital examiners, have access to and use the other examiners' notes, and probably discuss the cases with the other examiners. This criticism is not meant to imply that the Department's examiners have an unfair bias toward hospitalizing people unnecessarily; it is only meant to suggest that Department examiners are less likely than others to disagree with assessments made earlier by their colleagues.

Language problems with some foreign-born doctors, who work primarily in the public hospitals, are an important consideration in prehearing examinations. Attorneys in Chicago believe that these doctors' poor language fluency makes it difficult for respondents to communicate with the doctors or to understand questions and statements from the doctors to them. The foreign-born doctors' incomplete understanding of English, especially its idiomatic uses, can lead to important misunderstandings and misinterpretations of statements made by respondents. Aside from possibly leading to inaccurate medical observations and diagnoses, the poor level of communication with foreign-born doctors can make respondents anxious and uncooperative. Language problems can be a barrier to establishing a positive therapeutic environment, thereby discouraging voluntary admissions and patient cooperation.

The Illinois statute specifies that when an examination is being done for purposes of certification, the examiner must tell respondent the purpose of the examination, that what he or she says may be disclosed in court, and that he or she has the right to remain silent during the

examination (3-208). If this is not done, the examiner will not be allowed to testify in court. The statute does not provide any exceptions to this requirement. However, the Governor's Report, which suggested this statutory provision, did intend some exceptions. For example, if the need for commitment became apparent only after an examination had begun, it would be appropriate for an examiner at that time to give this information to the person and continue with the examination. Further, "These disclosure requirements . . . do not apply to the traditional therapist-patient relationship . . ." (p. 38) (although that qualification does not indicate unambiguously whether or not the "traditional therapist" would be allowed to testify at a hearing without having made the proper disclosures). And, although the statute does not say so explicitly, the Governor's Report states that the failure to give this information to respondent prior to an examination is not to invalidate the certificate but is only to prevent the examiner from testifying in court.

Doctors and other examiners do not like to begin examinations by "reading the rights" to respondents. Most feel that this instantly destroys any chance for a candid exchange in an atmosphere of trust and support; rather, it creates an attitude of resistance and defensiveness. A compromise point of view is that the legal statements should be made once to respondent prior to the first examination, perhaps not even by the examiner; but the rights should not be required prior to every examination that is done. A significant minority of others, though, disagree. In their opinions and experience, respondents are pleased that an examiner levels with them in this manner and the result is an enhanced atmosphere of trust and cooperation. Few examiners, regardless of attitude, report circumstances in which respondents refuse to talk with them as a matter of legal right (although many refuse because they are either hostile or too sick to communicate).

Many examiners reportedly do not always make the required disclosures to respondents prior to the examination. Some are unaware of or do not fully understand the requirement; others consider the requirement inappropriate and ignore it as a matter of principle; and some reportedly ignore the requirement to assure that they will not be required to testify in court. Some examiners routinely do not make the disclosures, but nonetheless indicate (falsely) on the certificates that they have made them.

Counsel for respondents report that judges have not consistently enforced the statute with regard to the required statements about respondent's rights to silence during the examination. They report experiences in which examiners have admitted in court that the right to silence was not disclosed to respondent by any of the examiners but the judge committed the respondent nevertheless. Some judges, on the other hand, have dismissed cases on the grounds that the disclosures were not properly made by both required examiners. The judges' decisions probably depend upon whether they give more regard to the need to "help" respondents in such circumstances or to protect their rights to liberty. The Illinois appellate courts have held firmly that disclosures are required prior to both certifying examinations for a commitment to be valid.

Despite examiners' general dislike for this requirement, and less-than-consistent treatment of the requirement in court, public defenders and other attorneys feel strongly that the disclosures are important. They point out that the respondent's statements become part of the court's public record and are used by succeeding examiners. They feel that the disclosure poses no problem for most examiners.

Reading respondent his or her rights prior to examination is thus an area of "fuzzy" law and practice in Chicago, and most agree that it probably should stay that way. Despite a tough statutory provision, the Governor's Report intended leeway for exceptional circumstances, and the statute does not invalidate a certificate filed after an examination at which the "required" disclosure was not made. Despite firm appellate court rulings, Chicago judges do not always dismiss a case in which the disclosures admittedly were not made. Despite their general unease with the requirement, doctors in Chicago do not believe that the disclosure requirments in the statute should be changed. In effect, the system appears to work on a "gentleman's agreement" of sorts: examiners are expected to follow the statute as closely as possible; but rarely is there any consequence if they do not.

Turning to other aspects of the prehearing examination, many of the attorneys and psychiatrists in the Chicago system feel that psychiatric reports and certifications sent to the court are too conclusory in their language. The underlying problem seems to stem from the effort to communicate psychiatric findings in lay language. Attorneys fault psychiatrists for communicating in technical jargon; but psychiatrists point out that the process of translating technical terminology into more common language forces them into making interpretations and conclusory statements. Attorneys and psychiatrists seem to agree that the best reports would be those in which psychiatrists could report their standard mental status examinations in their usual manner and then follow this up with an interpretation and conclusion presented in lay language.

Judges seem to fault the prehearing examinations mostly for their lack of useful information about respondent's social history and background. In practice, an important element in the decision of whether or not to release a respondent is knowledge of the community resources that are available to provide food and shelter for the respondent. Judges would like a more extensive social history to be performed as part of the prehearing examinations and to have the results available to them at the time of the hearing.

With regard to this, it should be noted that the Illinois statute calls for a special examination for any respondent who is being committed because of the inability to care for basic physical needs (1-119). Within seven days of admission to any mental health facility under this provision, respondent is to receive a comprehensive physical and mental examination and social investigation. The purpose of this "pre-admission examination" (as it is referred to in the Governor's Report at page 14) is to determine whether some program other than hospitalization, preferably in the community, will meet this person's needs. Judging

from judges' dissatisfaction with information about social background that is provided to them at hearings, we suspect that the comprehensive examinations specified by the statute are not being performed satisfactorily in all cases.

H. PREHEARING TREATMENT

Illinois statute allows hospitals to treat respondents as soon as a first examination and certificate have been completed (3-608). In practice, medication is frequently given at this point. Chicago hospitals all recognize respondent's right to refuse treatment, including medication. If respondent refuses medication, this refusal will be honored except in emergency cases that endanger respondent or others. (The right to refuse treatment is discussed more completely in Chapter X.)

In practice, then, most respondents are medicated shortly after they are admitted to hospitals and their medication is continued during the time that they are presented for judicial hearing. Controversy exists over whether or not mental health patients ought to be medicated at all and even more controversy exists regarding their medication at a judicial hearing. On one hand, a patient who is medicated effectively will frequently make a better appearance before the judge because he or she is under greater control and will not display gross symptoms of psychosis that will frequently influence a judge to order commitment. On the other hand, medication (primarily a problem of overmedication) can work against a respondent during a hearing. Medication sometimes will cloud a person's thinking rather than sharpen it and diminish the respondent's ability to testify effectively on his or her own behalf. Undesirable side effects of some medications also give people the appearances of being mentally ill, which works against them during a hearing.

I. PREHEARING DISMISSAL AND DISCHARGE

This report has already considered several ways by which a person may be released prior to a formal hearing. If either of the two required examiners does not find that the respondent meets the statutorily prescribed criteria, the respondent is immediately released and the case does not proceed to a judicial hearing. If the respondent's symptoms remit during the period of time preceding the judicial hearing, the hospital will discharge the patient; these cases have been entered onto the judicial docket but will be routinely dismissed.

A majority of respondents who are detained following the preparation of a petition for involuntary commitment decide, prior to the judicial hearing, to seek admission on a voluntary basis. In most cases, voluntary admission is to the benefit of all parties, and is approved. Counsel verifies for the court that the admission was indeed voluntary and the court routinely dismisses these cases.

Strengths and Weaknesses

The following paragraphs address strengths and weaknesses of the prehearing phase of Chicago's system for civil commitment. As pointed out in Chapter IV, some elements of the system may be both a strength and a weakness, if viewed from different evaluative perspectives. Thus, the benefits derived from a practice must be balanced with its costs to determine its overall value to the system.

A. LEGAL PROTECTIONS

Probably the foremost strength of the of the Chicago process of implementing the civil commitment laws is the wide array of legal rights and protections afforded the respondent. By statute, hospital policy, Department of Mental Health and Developmental Disabilities administrative rule, and the everyday practices of counsel, an extraordinary concern is shown for the legal rights of all individuals involved in this process, particularly for the respondent, in our opinion. The Illinois statute and the implementation of this law in Chicago stand among the best of which these researchers are aware in safeguarding people in their roles as patients and litigants.

Another strength of this system is the relatively short time that respondents typically are held in detention prior to a hearing (generally less than one week). This short detention period minimizes the state's intrusion on a person's liberty interests without a judicial hearing. The statute's provision for remaining at home prior to a hearing is also a strong point, despite the rarity with which it is employed. Albeit a rare event, the statute makes it possible to schedule examinations and a hearing without confining a person to a mental health facility if it is not necessary.

Judges may initiate commitment proceedings based upon their observations in a court. This is a good feature in a law if it is used as it is intended. It enables judges easily to transfer people from the courtroom (primarily criminal defendants) to mental health treatment facilities, when such treatment is apparently needed.

Allowing respondents to request voluntary status makes it possible for them to avoid the stigma of involuntary commitment and prevent the record of a commitment hearing from becoming part of the court's public record. Bolstered by the process of having counsel certify the voluntary request, as a check that patients have not been coerced into such actions, this is a laudatory element of the system.

Another good element of the statute is its provision for an independent examiner. Because of the enormous influence that examiners have in commitment cases, it is important that respondent have the ability to introduce another perspective into the judicial hearings and to check on the validity of the original examiners' findings.

Providing treatment to respondents prior to a hearing is another advantage in this system. It may enhance respondent's ability to assist counsel on his or her own behalf both before and during the hearing. At the same time, respondents have a right to refuse treatment, unless they present a danger to themselves or others. In this way, those who believe they will be adversely affected by treatment during the time of their hearing will not be forced to accept such treatment and will be able to make what they feel is their best effort in the legal battle against involuntary confinement. Finally, the statute is strong in providing for immediate discharge if either of the two examining physicians fails to certify the respondent as being in need of hospitalization, or if the respondent's symptoms remit sufficiently during the period preceding the judicial hearing. Although a legal action has been initiated, it is far better that the respondent be released immediately (if the basis for holding him or her in custody is not clear) than to hold respondent and continue the judicial proceedings.

The commitment system in Chicago also has a number of weaknesses in addition to its many strengths. For example, many attorneys consider it a deficiency that there is no requirement for an overt act to be specified in the petition or as evidence in support of involuntary commitment. The mental health literature (cited in the 1976 Governor's Report) strongly supports the conclusion that the professional's prediction of dangerous behavior (either against self or others) is often erroneous. Psychiatrists and other mental health professionals receive no special training in recognizing the potential for dangerous behavior. Many writers and commentators feel that because the ability to predict dangerousness is so poor, strong attention should be given to actual, overt behaviors of a dangerous nature in which respondent has engaged in the past. It is too easy and inaccurate merely to speculate about dangerous behaviors that respondent might engage in in the future; the potential for danger is much more believable if it can be shown that respondent already has made threats or engaged in acts of a dangerous type. Counsel for respondents in Chicago express the opinion that a person should be detained only when allegations have been made, and there are reasonable grounds to believe, that threats or dangerous behaviors have occurred, not when there is a belief that such acts are merely a possibility.

Another weakness in the Chicago system from the point of view of defense counsel is the judge's ability to initiate a petition based upon observations in the courtroom. This statutory provision can be regarded as a strength; but it can become a weakness if judges "misuse" this provision to keep a respondent in custody when the respondent otherwise would be released because of legal deficiencies in the State's case.

While the short period of prehearing detention resulting from the Illinois statute is generally a strength, it also has some legal disadvantages. Public defenders feel hard pressed to prepare their cases adequately in this time interval. It is especially difficult to arrange for witnesses on the respondent's behalf. This disadvantage is not a particularly great one, however, because continuances can be used to

extend the time period prior to the hearing if it is in the respondent's best interest.

While the Illinois statute provides a myriad of legal rights and protections, and while the Chicago system generally acts to enforce these rights, the system fails in practice to communicate effectively with respondents about their rights. Written statements of rights provided to respondents seem to be too complex for respondents to understand fully. Hospital staff do not have the inclination and do not take the necessary time to explain patient rights fully. There will be some debate about the extent to which most of these people are able to understand their rights, and hence about the utility of trying to do a better job in this regard. The extent to which these countervailing arguments determine policy will be decided, of course, by the participants in this process; but to whatever extent legal rights are not understood or used by the people to whom they are guaranteed, this must be viewed as a concern for the system.

Another point of concern is the conclusory and non-independent nature of medical certifications. Psychiatric diagnoses are not without error. Therefore, it is important to understand the facts upon which a diagnosis is made and to have the points of view of several examiners working independently to understand a respondent's condition. The commitment system in Chicago suffers from failing to include factual statements on all medical certificates and from allowing examiners the opportunity to be influenced by information and conclusions drawn by others.

Finally, in the opinion of some attorneys, it is disadvantagous to have respondents medicated during their court hearings. If medication is given in too high a dosage, this interferes with the respondent's ability to communicate effectively in court and to assist counsel in his or her defense. The side effects of medication also may create the appearance that a person is mentally ill and may influence the judge's decision.

B. PROVISION FOR TREATMENT

By far, the major strength of the Chicago system is its network of community mental health centers. The community centers offer a wide array of services to all Chicago citizens, regardless of means. The large number of centers, along with their community orientation, makes it easy for people to receive help. This probably prevents large numbers of people from needing extensive inpatient care that would otherwise be provided through hospitals, which are already crowded and under pressures to reduce their patient populations. The mental health centers also provide an effective network for aftercare services for patients who are released from hospitals. Patients who can receive effective treatment through outpatient clinics may be less likely to have a recurrence of their original problems and reenter the judicial system for involuntary commitment.

Another advantage of the Chicago system is that is permits people to enter the hospital easily as voluntary or informal patients. It is generally believed that the course of treatment will be quicker and more effective if a patient is cooperating rather than being forced to participate. The avoidance of a judicial hearing and the greater control that respondent retains over discharge act as incentives for respondents to seek voluntary admission.

Although it was mentioned above as a weakness from a legal perspective, the fact that no overt act or threat is required to justify a commitment is considered a strength in this system from a treatment perspective. Doctors, especially, feel that mentally ill people make statements that are precursors to violent activities but that are neither threats nor explicitly violent behaviors. While the frequency of actual violence following such statements may be low, the tragic consequences of violence when it does occur justify the commitments in these circumstances, in their opinion. Thus, it is beneficial to be able to treat people even without demonstrating overt violent acts or threats in order to avoid harm and violence that may occur, even if the likelihood of the occurrence is relatively low.

It is beneficial for treatment that the statute allows doctors to begin treating patients as soon as one certificate of examination has been completed. Particularly in circumstances of an acute mental health incident, prompt treatment is most efficacious. Treatment that is provided quickly may even allay the respondent's problems sufficiently so that he or she can be discharged before the judicial hearing.

To the extent that commitments involve two independent examinations, this is beneficial with regard to treatment. Having multiple examinations increases the confidence in diagnosis and ensures that appropriate treatment will be prescribed for a patient.

The Chicago civil commitment system also has some weaknesses with regard to treatment. The short amount of time that a person is detained prior to hearing, for example, is an advantage from a legal point of view; but from a treatment point of view, a longer time interval would give people a better opportunity to be treated and released without bearing the stigma of having been committed involuntarily at a judicial hearing. (Note that this would be especially true if court records could be expunged in such cases.)

Similarly, the extensive concern for legal rights and protections is beneficial from a legal standpoint, but can be detrimental for purposes of treatment. Patients who are already confused and suspicious may be overwhelmed and made highly uncomfortable by being subjected to readings and explanations of legal rights with which they may not be concerned at that time. Hospital staff already feel that a zealous concern for legal rights has brought unnecessary paper work and quasilegal activities that they do not fully understand, have not been trained for, and have had imposed upon them unjustifiably. These activities take up time that staff could be using to help patients.

Further, the legal restrictions frequently are considered to have limited the discretion of hospital staff to treat patients in a manner that staff sees as appropriate and necessary.

Another weakness in the Chicago system stems from the language difficulties of the foreign-born doctors. As pointed out earlier in the report, language problems make it hard for doctors and patients to communicate effectively. This potentially interferes with correct diagnosis and effective treatment.

The lack of adequate information about respondent's social background, perceived by judges, is another source of weakness. Judges feel that this information is necessary in order for them to make correct decisions about release and treatment. The knowledge that respondent has a supportive family or religious group that can provide the necessary care and supervision, for example, is critical to a judge who is considering whether or not the respondent can remain at liberty in the community.

C. SOCIAL BENEFITS

Several features of the Chicago system are advantageous for the people of Chicago primarily because they are cost effective. Among these, the city's network of CMHCs is foremost; treatment provided through a distributed system of community centers is more cost effective than providing the same services from hospitals. It is cost effective, too, to have so many patients enter the system on a voluntary basis, because this eliminates much of the need for judicial resources and attorneys. The system also benefits by the screening services provided by the state's attorney and the Chicago police department. From all reports, it appears that these individuals do an effective job of screening out inappropriate cases. This reduces judicial costs and avoids the cost of establishing a separate screening mechanism.

The brief period for holding respondents prior to a hearing also has important social benefits. The cost of detaining a respondent is relatively low. The holding period, and its associated costs, may be expanded by continuance only if good cause is demonstrated. It is also a benefit to society that the question of whether a person should be committed can be taken to trial and resolved in a relatively brief time.

The Chicago police department provides an important service to the city in its assistance in transporting patients. Police involvement ensures that patients and the public will be kept safe and that patients can be taken quickly to mental health facilities when their safety or the safety of others is threatened. People respect the police, thereby making officers highly credible agents to perform necessary screening functions in this city.

Important benefits arise in those (admittedly infrequent) cases in which a respondent may stay at home pending the hearing. Society does not bear the burden of supporting the person for the prehearing period and the family may benefit by the person's continued presence at home.

An important benefit accrues to society because the statute allows facility directors and judges to reject a respondent's application for voluntary admission. Without a provision like this in the statute, it would be possible for potentially dangerous mental health patients to manipulate the system. If dangerous mentally ill persons were able to request and receive voluntary admission at any time and then sign themselves out of the hospital within a period of five days, this would increase the costs to society by increasing the frequency of involvement by police and the courts, and increasing the potential danger to citizens.

There are, of course, social disadvantages stemming from the Chicago system as well. Clearly, broad legal rights cost money to enforce, require greater commitments of time and personnel, and add complexity to a commitment system. These social disadvantages must be weighed against the benefits that accrue to those individuals whose rights are protected. An example is the recently instituted practice of requiring counsel to certify that requests for voluntary admission were made voluntarily. This has placed a greater burden of work on the public defenders, thereby taking away from their time to work with other defendants who may need them. Again, the benefit of protecting respondents from possible abuse was considered important enough to justify the countervailing disadvantages.

Another major disadvantage from a societal perspective is the statutory provision for respondent's right to refuse treatment. Some people believe that if a person has been certified by a qualified examiner as being in need of hospitalization and treatment for a mental problem, it is inconsistent to allow that person to refuse the required treatment. This will be discussed again at a later section of the report because the right to refuse treatment may be viewed differently at the prehearing stage than it would be at the posthearing stage. For example, the right to refuse treatment might be considered more justifiable during the prehearing period than posthearing if one believes that medication seriously interferes with the ability to present one's case in court. To the extent that treatment is justifiable and would produce beneficial effects for the person and society, however, the right to refuse treatment can be viewed as a harmful barrier.

Recommendations

VI.1. (**) Training should be made available for the Chicago police on the nature of mental health disorders, how to communicate with and handle mentally disordered people, and community resources to which mentally ill individuals may be taken. The Chicago police play an important role in screening and transporting mentally ill individuals. They frequently are

called upon to decide whether or not mental health facilities are appropriate for a person on the street and the exact nature of help that is needed. Although the police are commended for doing a fine job in the Chicago area, we recommend that training programs and supporting educational materials be made available for the police to help them do this job. An inexpensive and minimal way in which to do this, for example, could be to arrange informal briefings for the beat officers, given by professional staff of the community mental health centers.

VI.2. (**) The court should encourage that specific overt acts or threats be recorded on mental health petitions whenever possible in support of the allegation that a person is dangerous to self or others or is unable to care for his or her basic physical needs. Without an overt act or threat requirement, a person may be taken into custody on the basis of conclusory statements and unsubstantiated opinions presented by a petitioner. The ability to predict dangerousness, even by professionals such as psychiatrists, has been seriously called into question. There is, of course, greater reason to believe that a respondent should be committed if evidence exists that the person already has made threats or engaged in specific behaviors that demonstrate danger to self or others or inability to care for basic physical needs. On the other hand, an absolute requirement for an overt act or threat may prevent the commitment and treatment of a person whom doctors believe has the potential to cause great harm. Thus, this recommendation encourages the court to seek reports of overt acts and threats as evidence whenever possible, but to commit without these in cases in which it seems prudent.

VI.3. (**) Doctors who are to examine respondents and prepare medical certifications should be required to display a minimal fluency in oral and written English. Although foreign-born doctors may be sufficiently prepared as physicians, their inability to communicate fluently in English can create serious problems when they work in the commitment process. Respondents must be able to understand psychiatrists if they are to provide valid information to the doctor in a positive therapeutic environment. Doctors must have a sufficient understanding of the English language if they are to interpret patient's responses accurately. Medical certificates and reports must be written in a manner that makes the information meaningful to attorneys and judges.

VI.4. (*) The certificate of examination should be changed to indicate clearly whether or not the examiner disclosed the respondent's right to remain silent during the examination as required by the statute. Statute requires that prior to every examination for purposes of certification, the examiner is to disclose the purpose of the examination and inform respondent

of the right to remain silent. As discussed at length in the text, attorneys feel strongly that this disclosure should be made prior to every examination without fail. Although this principle is not disputed, mental health examiners admit that "reading the rights" frequently is not done as required, and there is seldom adverse consequence of violating the statute in this manner. While few if any would endorse a change in either the practice or the statute, there is consensus that the certificate should record accurately whether or not the respondent was properly informed about the examination and his or her rights. It is recommended, therefore, that the form of the certificate be changed so that the examiner is required to indicate this information clearly and honestly.

VI.5. (**) Prior to the judicial hearing, the mental health facility should be required to make an investigation of respondent's social and family situation and provide the findings to the judge. The statute already requires this for those allegedly unable to care for basic physical needs (1-119), and probably also requires it, in effect, for those alleged to be dangerous (i.e., a treatment plan must be presented at the hearing and most treatment plans incorporate social background information). The information is particularly important to judges in determining whether a patient has sufficient resources available in the community, or whether alternative treatment modes are appropriate, so that hospitalization is not required. In practice, however, this information seldom is provided as intended by statute. Mental health staff explain that preparing such a report within the five-day prehearing period is extremely difficult, especially with the diminished resources with which they currently must function.

Having a report for every case, as required by statute, probably is an ideal toward which to strive, but whose attainment may be impossible. Some compromise is possible. For example, given the diminished mental health resources, it makes little sense to perform a vigorous social history investigation for respondents who, if they are to receive treatment, certainly will need to be hospitalized. Full investigations might be undertaken selectively, in those cases appearing most likely to benefit from them. In cases in which the information was not obtained, but in which it is deemed to be important, a seven-day continuance can be ordered during which the necessary investigation can be completed. (The obvious disadvantage to a continuance is the respondent's continued detention. But detention for purposes of exploring alternative community placements is preferable to what may presently happen: prolonged commitment to a hospital because treatment is needed and no social investigation has been performed.)

VI.6. (***) Examining psychiatrists should provide, at a minimum, a full standard mental status examination report as part of the medical certification. This information would provide the factual bases on which psychiatric conclusions are drawn. Psychiatrists can be encouraged to supplement this information with their professional conclusions and an interpretation of the information in lay language. The court can request that these reports be explained at the hearing by qualified examiners, who are required by statute to be at the hearing. This information, included with the certificate, will provide greater proof that a careful psychiatric examination has been done and will provide the factual basis for psychiatric opinions and diagnoses.

The question of what constitutes a "standard" mental status examination undoubtedly will generate differences of opinion among psychiatrists. This should not detract, however, from the value of this recommendation, although it might make it harder to implement. After consultation with the mental health community, it might be useful carefully to define what a "standard" examination is, either in statute or by court rule.

VI.7. (**) A procedure should be devised by which an independent examiner can be appointed quickly and inexpensively, such examiner to be independent of the Department of Mental Health and Developmental Disabilities and to be available for examinations and presentation of results within a short period of time. The availability of an independent examiner is important to help establish the reliability of psychiatric testimony. Because the testimony of examiners is so influential in these cases, testimony that fails to corroborate the original psychiatric conclusions will be an important factor in the presentation of respondent's case. The exact manner by which independent examiners can be made available depends upon mechanics and circumstances that must be worked out in the city of Chicago. Other cities have used court-appointed private psychiatrists, who are made available to respondents and paid by the state when their services are used. To minimize costs, the psychiatrists need not be involved in every case. They can be "on call" at the hospital or in a nearby office, available to provide an independent examination within a couple of hours if so requested by the public defender. Because the Illinois statute intended that this important resource be available to respondents, and because it currently is not truly available, some mechanism should be established so that an independent examination can be obtained when it is desired.

VI.8. (***) Examiners who prepare certificates should be required to report what psychiatric records and other examiners they consulted with before examining respondent and preparing the certificates. They should indicate, if possible, which of their conclusions depend substantially on their own observations and which primarily echo or reinforce prior conclusions made by others. A qualified examiner should be able to diagnose the presence of mental illness by examining a patient (and perhaps by reading a petition) without consulting other examiners or their notes. If records of previous psychiatric treatment are available to examiners, this is likely to produce a strong bias in an examiner's conclusion that respondent is mentally ill.

Doctors point out that previous psychiatric records are necessary for an exact diagnosis of a mental illness. While such records are frequently useful in making a differential diagnosis, it is doubtful that they are required to determine simply whether or not a person is mentally ill, which is all that is necessary to satisfy the statutory critera. The problem is not merely legal, however. It also is a medical problem, because the examination is used for treatment purposes as well as to establish respondent's legal status. Treatment staff have a valid and important need for psychiatric histories and other examiners' opinions and records in planning treatment strategies.

Because examinations serve both legal needs and treatment needs, a dilemma is created. From a legal standpoint, examinations should be independent and uninfluenced by previous treatment histories and other opinions. From a treatment standpoint, this information is critically necessary. This recommendation, therefore, is to allow examiners to refer to records and confer with other examiners prior to the examination; but it suggests that they report the nature and extent of information that might have influenced their conclusions about respondent's condition. From this, the judge can determine whether enough current and independent evidence exists to justify respondent's commitment.

VI.9. (***) Written information given to respondents regarding their legal rights and protections should be rewritten in simpler language. Statements of rights typically seem to be written and provided to patients more to satisfy the letter of the law than to provide information to patients. To be effective, these statements of rights need to be presented in simple language. Additional information can be available and provided to patients who request a more thorough understanding of their rights.

VI.10. (*) Time and care should be taken to speak personally with every respondent in order to explain clearly the respondent's legal rights and protections, and the treatment and commitment process. Prior to doing so, respondent should be asked whether he or she wishes to engage in this conversation, so that this verbal explanation of rights can be waived at respondent's request. While it is important that all respondents receive a written statement of their legal rights and protections, their understanding of these materials will be enhanced significantly by a personal discussion and explanation. Additionally, respondents need to be informed about hospital procedures, what will happen to them during the prehearing and hearing processes, how to request services, and so on. On the other hand, it has been pointed out that such discussions may be anti-therapeutic or, at best, of no current interest to the respondent. Respondent's conditions and interests should be taken into account so that those who are interested in these rights can have them explained fully, but making it possible to eliminate these conversations at respondent's request.

VI.11 (**) All involuntarily committed patients should have guaranteed access to telephones and should be provided with a reasonable sum of money upon request if such telephones are pay telephones. The Illinois statute guarantees patients limited rights to unhindered communications. Some hospitals provide patients access only to pay telephones; patients who do not have money for these telephones may be denied their rights to communication. Because of their states of mind, mental patients occasionally have been known to abuse telephone and other communication privileges by communicating with enormous numbers of people or people who are clearly inappropriate (e.g., the Mayor, the President of the United States, the Pope). This should not be used as an excuse, however, to hinder legitimate communication attempts. Patients should be told that they will have access to telephones for a reasonable number of calls and that money will be provided to them if necessary. While hospital staff will need to be charged with responsibility to protect this right, it may be appropriate to charge the expense for telephone calls to the budget of the court, the public defender, or the Guardianship and Advocacy Commission.

VI.12. (***) It should be required that at the time of a judicial hearing, the court should be informed of the complete history of medication that was provided to the patient during the prehearing period, and the probable effect that it currently has on the respondent and his or her ability to assist counsel and to testify in court. As explained in the report, much controversy exists over the medication of patients, especially before the conclusion of a full hearing. The respondent's ability to assist counsel on his or her own behalf and the

respondent's appearance and behavior in court are important factors in determining the outcome of a hearing. Judges should be informed in every case about the extent to which respondent is under the influence of medication so that this might be taken into account in determining the outcome of the hearing.

CHAPTER VII. COUNSEL FOR THE RESPONDENT

Description

Respondent's counsel becomes involved in civil commitment cases before the hearing takes place. Legal issues, which may involve an attorney to represent respondent's interests, arise during all phases of the commitment process. Before the hearing, an attorney is necessary to explain legal rights and options to respondents. During the hearing, counsel is primarily responsible for presenting the respondent's case and representing his or her interests to ensure that the entire process is performed correctly and quickly. During a period of hospitalization, attorneys may become involved in issues of patient's rights and avenues for seeking discharge. An attorney's help will be needed again if a patient is held for the full period of commitment and the hospital then petitions for his or her continued retention.

A. APPOINTMENT OF COUNSEL

Every respondent facing possible involuntary commitment in Chicago is represented by counsel. For all intents and purposes, counsel is assigned by the court at the time the petitions and certifications are filed. The vast majority of respondents are represented by public defenders in Chicago, although some will be represented by privately retained counsel, private appointed counsel, or attorneys from the Guardianship and Advocacy Commission.

Respondents in Illinois have the right to represent themselves at commitment hearings, with the consent of the court (3-805). In practice, however, this happens rarely. It is not so rare that respondents will reject the assistance of counsel, sometimes because they want to represent themselves in court, but more frequently because they are suspicious of the public defender or as a manifestation of their generally confused state. In these situations, judges most frequently give the respondent the right to present his or her case in court, but request that the public defender stay at respondent's side in court to "help out" the respondent. This arrangement seems to work well because it does not force counsel upon an unreceptive client but it does make counsel available if and when the client feels the need for legal assistance.

Public defenders report, however, that if respondent wishes to represent him or herself, the public defenders occasionally are directed to provide legal assistance <u>if and only if</u> the respondent requests help. This causes problems because respondents frequently do not know when they need help. Counsel must remain silent at a hearing, for example, while evidence is introduced that counsel (but not the respondent) realizes should be objected to. Further, appellate court cases have established the principle that respondent may not appeal on the basis of ineffective counsel in such cases. Thus, placing restrictions on the public defender's freedom to "help out" in these cases can cause significant difficulties.

For the most part, the public defenders in Chicago do an excellent job of representing respondents in civil commitment cases. Interviews with people in the Chicago system reveal that the public defenders have different skills and styles. Taken as a group, however, they apparently have an excellent knowledge of the relevant law and a strong commitment to performing their services in a conscientious and professional manner. The legal services given to respondents in Chicago by the public defenders, in the observation of these researchers, is vastly superior (from a strictly legal perspective) to comparable services provided in other cities through systems of appointed private counsel.

Appointed counsel in Chicago are responsible for their clients primarily during the prehearing and hearing phases of the commitment process. Neither by statute nor in practice is there an apparent effort to maintain the client-attorney relationship once a patient has been committed to treatment. (Public defenders will represent defendants in cases regarding patients' rights, discharge hearings, and so on. But the attorneys are assigned as the cases come to the attention of the courts. No formal system exists for the public defender to keep track of his or her "clients" during their hospitalization in case legal help should be needed later, although the public defenders try informally to stay in touch with and available to patients as best they can.)

B. DETERMINING INDIGENCY

Illinois statute requires that counsel shall be appointed for indigent persons (3-805). In practice, no effort is made to determine whether or not a respondent is indigent. Unless a respondent has retained a personal attorney, the court appoints counsel (usually a public defender) in every case.

C. THE ROLE OF COUNSEL

In the extremes, two roles are possible for counsel who represent respondents in involuntary civil commitment cases. Attorneys may play the role of staunch advocates, "battling" in court for that which their clients desire, which is usually prompt discharge from the hospital and dismissal of the case. At the other extreme, attorneys may play the role of guardian ad litem. In this role, they determine and work for what they feel is in their client's best interest, which may be a discharge from the hospital, as the client wishes, or continued custody and treatment, which may be contrary to client's expressed wishes but congruent with the attorney's perception of what the client needs.

Judges in Chicago disagree among themselves about which of these roles is most appropriate for attorneys to take. The dominant feeling of the court, however, is that attorneys for the respondent should act as a strong advocate. The Illinois statute is well suited to this role for respondent's attorney: a heavy emphasis is placed on legal rights and protections; a state's attorney presents the case for hospitalization;

and hearings are held with formal adherence to rules of civil procedure and evidence.

The public defenders, for the most part, assume the role of advocate rather than guardian ad litem. The public defenders in this system differ amongst themselves in attitudes and skills, however, and some advocate more strongly for their clients than do others.

Private attorneys and mental health advocates in the Chicago area seem to feel that the public defenders do not advocate for their clients as strongly as they should in many cases. They acknowledge that there are differences among individual public defenders and they probably would characterize the legal advocacy of the public defenders as ranging from satisfactory to quite good. These attorneys and advocates agree, however, that significant improvements still could be made in the quality of legal services provided for respondents in Chicago.

D. ADEQUACY OF REPRESENTATION

The Illinois statute (3-805) specifies that counsel shall be allowed time for adequate preparation and shall not be prevented from making an investigation of matters at issue and relevant evidence. The court in Chicago, particularly under the influence of Judge Joseph Schneider, has been adamant in requiring counsel to meet personally with clients prior to the hearings in order to prepare their cases for court. Judges encourage adequate preparation by counsel by asking counsel whether and how they have checked with their clients regarding matters that arise before the court.

Public defenders in Chicago, who represent most of the cases, are conscientious about their responsibilities but clearly are overworked. Everyone in the professional mental health and legal community concedes that there are too many mental health cases for the number of public defenders available to represent them. The public defenders meet with every civil commitment respondent without fail; but they admit that they have too many cases to be able to do a thorough job of preparing for the "really tough ones." The heavy load and short time period not only make it difficult for public defenders to prepare for cases as well as they would wish but also make it difficult for them to spend time with their clients to explain the legal procedures and discuss legal strategies. It is particularly difficult for public defenders to identify witnesses and make arrangements for them to be at the hearings.

Public defenders report that their access to necessary information is satisfactory. It might be noted, however, that this is a fortunate circumstance of the way the system operates rather than a provision of law. Section 712 of the Guardianship and Advocacy Act assures access for Guardianship and Advocacy Commission attorneys to all mental health records, and the Illinois statute on civil commitment says generally that counsel shall not be prevented from making an investigation of relevant evidence (3-805). The Mental Health and Developmental Disabilities Confidentiality Act, however, if read literally, would prohibit the public defender from access to hospital

records about his or her client without the explicit consent of respondent. Again, hospitals apparently have not restricted the public defenders' access to these records, but they probably could do so under the provisions of the Confidentiality Act if they wished. In such cases, access would not be a problem if respondent authorized the public attorney's access. Some mentally ill respondents, however, acting unwittingly against their own best interests, might refuse to authorize such access for the public defender and thereby place counsel at a distinct disadvantage in representing his or her case.

Strengths and Weaknesses

A. LEGAL PROTECTIONS

The system for providing counsel to civil commitment respondents in Chicago has many strengths. Foremost among these is the public defender system that is used in most cases. The public defenders are a conscientious and well-informed group who provide competent and thoughtful counsel and may be assigned to anyone in the city who needs counsel. Although the statute allows for the appointment of private counsel to indigent cases, the observations of these researchers in other cities leads to the strong impression that appointed private counsel do not provide legal services of equally high caliber or consistency.

The Chicago system also benefits greatly in that public defenders are encouraged to assume the role of strong advocates. Systems that tolerate a guardian ad litem approach to representation do not provide respondents with the same vigorous legal representation.

By order of the court, appointed attorneys are required to meet personally with all clients prior to a hearing. Observations in other sites made it apparent to these researchers that attorneys do not do a sufficient job of representing clients when they meet their clients for the first time shortly before a hearing begins. If clients are to be represented effectively, it is necessary that attorneys meet with them well before the hearings to discuss the case and confer about facts, witnesses, legal strategies, and so on.

Another positive aspect of the Chicago system is that attorneys have excellent access to all necessary court and hospital records. It has been noted above that there may be legal grounds upon which attorneys' access to hospital records might be constrained. In practice, however, attorneys have had no problems in acquiring all of the information they have needed to prepare sufficiently for their cases.

The major disadvantage to the system as it presently operates is the excessive workload of the public defenders. Of course, decreasing this workload can be done only at enormous cost. Either more public defenders need to be assigned to cases, or time must be taken from some respondents or classes of respondents to make more time available to work on cases for others. Notwithstanding the costs and related difficulties in alleviating this problem, respondents in Chicago currently are not

receiving all of the legal assistance that could be provided them by the current public defender's staff because of the staff's heavy work burden.

B. PROVISION FOR TREATMENT

The method of providing counsel for respondent does not particularly contribute in any way to the efficacy of providing treatment. If anything, it may be somewhat disadvantageous for treatment purposes. Counsel who represent clients in the role of strong legal advocate frequently are criticized for overlooking the fact that their clients may be in need of help. Hard-nosed advocacy, it is charged, may result in a patient's release because of a legal technicality or by taking advantage of poor preparation by the assistant state's attorney. Despite the client's spoken wishes for discharge, a patient who is, in fact, in need of mental health treatment may be discharged immediately to his or her detriment. Occasionally, a zealous advocate might even effect the release of a seriously ill patient who had no intent of "putting up a fight." It should be noted that in such cases, however, it is not the strong advocacy of the client's attorney that really is the problem--it is the existence of inadequacies in the state's presentation of the case that is at fault. The adversary system of law depends upon competent presentation of both sides of an issue to extract the truth of a matter. The problem of balance is not created by those who do their jobs well but rather by those who may do it poorly. Thus, in our opinion, this characteristic of the Chicago system might be cited as a disadvantage from a treatment perspective, but not as a serious one.

C. SOCIAL BENEFITS

The major social concern that is served by the system for representing respondents is that competent defense counsel is provided to everyone in the city, including those who are unable to afford counsel on their own. On the other hand, arguably the system suffers because no attempt is made to determine indigency; thus, some respondents who might have the ability to pay for counsel are not required to do so. Because the public defenders' workloads are so heavy, the benefits of having respondents provide their own counsel or pay for counsel provided to them would be immediately evident.

Recommendations

VII.1 (***) The court should continue to encourage, and further encourage, public defenders and other appointed counsel to act in the role of vigorous advocates for their clients. Civil commitment hearings in Chicago are adversary in nature and provide for an assistant state's attorney to present the case for the state. The statute establishes an adversary procedure for extracting the truth about the respondent and prescribing the best course of action for him or her and for society. In order to utilize the adversary system and behave as the statute intended, it is imperative for public defenders and other attorneys to act as strong advocates for their clients'

stated desires. Of course, conscientious attorneys will meet with their clients and try to assist them to understand various courses of action and choose the best options for their personal situations. But once an attorney has provided such counsel, he or she must represent the client's stated interest as effectively as possible. Equally important, the state's attorney also must be an effective advocate in cases where hospitalization appears to be necessary.

VII.2. (***) Ways should be identified to lighten the workload of the public defenders. The Illinois statute requires that "counsel shall be allowed time for adequate preparation" (3-805). Everyone who is familiar with the work of the public defenders agrees that they handle too many cases to have time for adequate preparation, contrary to the dictates of statute. Some in Chicago call the group of attorneys who take the commitment cases the "stepchild" of the public defender's office. They charge that the public defender's office gives these attorneys the lowest possible priorities for resources and that they have workloads many times greater than other attorneys in the office.

Several possibilities can be suggested to implement this recommendation. More attorneys can be hired. Additional attorneys in the public defender's office can be assigned to commitment cases. Or, consistent with the intent of the Guardianship and Advocacy Act, more cases can be assigned to Guardianship and Advocacy Commission attorneys (see related discussion in Chapter XI). This recommendation will be difficult and costly to implement in any manner. But in the opinion of many legal and mental health professionals in Chicago, this may well be the most important recommendation in this report.

VII.3. (*) The Mental Health and Developmental Disabilities Confidentiality Act should be amended so that counsel representing civil commitment respondents are guaranteed free access to all relevant hospital records. This apparently is not a problem, in practice, at this time. It could be argued from existing statutory language in the Mental Health Code and in the Guardianship and Advocacy Act that such access is already guaranteed. Nonetheless, a clear statement in the Confidentiality Act would remove any possibility that this might ever become a problem.

VII.4. (*) Ways should be explored to arrange that respondents who can afford to reimburse the state for the expenses of providing a public defender should do so, or should be encouraged to retain private counsel. An important strength of this system is that counsel is provided to all respondents with a minimum of "red tape" or delay. On the other hand, the enormous demand placed upon the public defenders probably is reducing the quality and quantity of the services that they

can provide to any particular client. If those respondents who are financially able are encouraged to add their resources to the system, and if this can be done in a manner that is not burdensome, this would provide a positive contribution to the system.

CHAPTER VIII. THE HEARING

Description

The purpose of this chapter is to discuss the events surrounding a judicial hearing on the question of whether or not a person shall be committed for mental health treatment. The chapter considers the detailed characteristics of the hearing, the various people who become involved in it, and the criteria that must be established to determine that a person is to be committed. Note that information in the next chapter is also relevant to determinations made during a hearing but is relevant only when the respondent is in need of treatment. This distinction, between determining whether or not treatment is needed, and determining the nature of treatment if it is needed, has been made primarily for the analytical purposes of this research project. Within the judicial hearing, consideration frequently is given to both matters simultaneously. The two considerations are separated in this report only for the purpose of clarity of thought and should not lead the reader to think that these issues are necessarily bifurcated in their consideration at hearing.

A. CHARACTERISTICS OF THE HEARING

By Illinois statute, it is mandatory that every respondent facing involuntary civil commitment have a judicial hearing within five court days of the time that he or she is taken into custody or that a petition is filed with the court (if the person is not in custody). With the exception of respondents who choose to enter a hospital on a voluntary status, a full judicial hearing is held promptly for every person against whom an involuntary civil commitment petition is filed.

Commitment hearings are held regularly at two hospitals in the city: every Tuesday and Thursday at Read Hospital for all respondents who are in hospitals on Chicago's north side; every Monday, Wednesday, and Friday at the Illinois State Psychiatric Institute (ISPI) for respondents who are patients in hospitals on Chicago's south side. A substantial majority of respondents will be hospitalized either at Read or at ISPI, which makes these sites convenient for hearings. Patients from other hospitals are transported to Read or ISPI for their hearings.

In special circumstances, hearings may be held in downtown Chicago at the Daley Center in the city's regular courtrooms. For example, all trials by jury are held at the Daley Center rather than in hospitals. Or, if a respondent is not being held at a hospital pending hearing, the hearing is downtown. Also, if a particular judge begins a case at a hospital and the case is continued past the time that the judge is assigned to hear mental health cases, the hearing is scheduled for the regular downtown courtrooms where that judge is hearing a regular schedule of cases.

With few exceptions, respondent is present at the hearing. By statute, the court is responsible for notification of the hearing time

and place to respondent, his attorney, and the director of the mental health facility that is involved (3-611, 3-706). Because these people are so closely involved in these cases, notification is, of course, not an important issue. The court is also responsible for notifying other people designated by the respondent, and respondent's "responsible relatives."

Respondent's right to be present at the hearing can be waived by motion of respondent's attorney if respondent's presence threatens "substantial risk" of causing "serious harm" to respondent (3-806). In practice, respondent's presence is almost never waived. A violent respondent is restrained to the best ability of the court and may be physicially barred from the hearing only as a last resort. Special hearings may be held in respondent's hospital room in cases where respondent is so gravely disabled that it is inadvisable for him or her to attend hearings in the normal place.

Respondent's have the right to request a trial by jury (3-802), but this happens infrequently. Jury trials are inconvenient because they must be held downtown where jurors are available. Jury trials take longer because they involve the extra process of jury selection and frequently result in a longer and more thorough presentation of evidence during the hearing. Those who have experienced jury trials in commitment cases say that the jury's presence has no influence upon the final decisions (i.e., the judges would have decided the cases the same way that the juries did). For these reasons, jury trials are viewed by the legal community as a great bother and delay, with no apparent benefit for the respondent, and attorneys generally advise their clients not to request a jury trial.

All involuntary commitment hearings in Chicago are open to the public, and the records of court proceedings are considered to be public documents. For good cause shown, attorneys can request that hearings be closed to the public. In practice, the issue of public access to the hearings is seldom raised and it is unusual that observers from the general public are in attendance. Although a considerable number of people observe hearings, it is probably safe to say that most "public" observers are either professionals in training (doctors, nurses, social workers, or college students) or researchers.

Courtroom proceedings are generally orderly and proper. Attorneys for counsel have pointed out that courtroom decorum is extremely important in civil commitment cases because of the sensitivity of the matters being heard and the generally high anxiety level of respondent and family members involved in these proceedings. When respondents are scared, anxious, or "paranoid," it is disturbing to them to see people in the audience whispering or laughing or to see attorneys holding informal discussions while a witness is testifying. Attorneys feel that courtroom decorum generally is maintained well but that judges need to be even more sensitive in this regard out of respect and concern for respondents.

The Chicago courts do not determine questions of liability for court costs in these cases, although statutory authority to do so exists (3-818 (b)). The court costs are borne by the Circuit Court, which is the judicial body that is authorized by statute to hear these cases.

B. CRITERIA FOR COMMITMENT

To be committed involuntarily in Illinois, a person must fall into one of two categories (1-119). Either the respondent must be mentally ill and, because of his or her illness, reasonably expected to inflict serious harm on self or others in the near future; or, respondent must be mentally ill and, because of his or her illness, unable to provide for basic physical needs so as to guard him or herself from serious harm. Given the state of the art in contemporary mental health law, these criteria seem reasonable, workable, and commonly accepted standards for civil commitment. If a respondent meets one of these criteria, he or she is judged to be "subject to involuntary admission."

In practice, evidence is presented during the hearings to establish one or both of these standards. Both sides explore specific and explicit evidence to establish a condition of mental illness and grounds for believing that respondent is either dangerous or substantially unable to provide for his or her own needs. The court requires clear and convincing evidence to support these contentions (3-808). Psychiatric jargon is not allowed as testimony without being explained in lay language. Conclusory statements by mental health staff or other witnesses are not allowed unless specific facts are presented to explain how such conclusions were reached.

Ultimately, of course, it is the judge who decides whether or not the evidence has been clear and convincing, whether conclusions have been supported adequately by the facts presented, and whether or not the respondent meets the statutory definition of a person who is subject to involuntary admission. Just as judges in criminal cases tend to be harsh or lenient, judges in civil commitment cases have differing attitudes towards the civil commitment process and thus different propensities in the types of decisions they make. These researchers have viewed hearings in several states and, acknowledging the wide range of differences among judges within any state, would characterize Chicago judges (as a group) as being relatively more toward the "liberty" end of the spectrum. For the most part, Chicago judges tend to be somewhat strict in seeing to it that sufficient evidence is presented to establish clearly that the respondent is appropriate for involuntary hospitalization. This seems consistent with the intent of the Illinois statute, although it may seem out of place in a system such as Chicago's where (as has been pointed out above) persons who make it to the stage of a judicial hearing are frequently much in need of help.

C. STATE'S ATTORNEY

An assistant state's attorney presents the case for hospitalization in every involuntary civil commitment case. Although some believe it is the state's attorney's job to represent the

petitioner, the statute specifies that the state's attorney is to represent "the people of the State" (3-101). The statute thus apparently gives him or her the discretion to pursue a case in the manner he or she thinks best for the public's interest, which may not necessarily be to advocate strongly for a respondent's hospitalization. The assistant state's attorney presenting these cases in Chicago reportedly does, in fact, make a personal decision about the merits of each case and present the case at the hearing as he or she feels is appropriate. In most cases, of course, hospitals will not retain patients and pursue commitments at a court hearing if they do not feel that the person is appropriate for hospitalization, and the assistant state's attorney usually will agree with and advocate for the hospital's point of view.

D. PETITIONER'S ATTORNEY

Although Illinois mental health code does not specifically state that petitioner may retain private counsel, it does state that no party to the hearing shall be prevented from retaining his or her own counsel (3-101). Few petitioners have their own attorneys at civil commitment hearings. In the rare case when this does occur, the assistant state's attorney usually does not participate and petitioner's attorney will present the case for commitment. The fact that petitioner is represented by private counsel probably does not make much difference except for those cases in which the assistant state's attorney feels that he or she would best represent the people of the state by not pressing hard for this respondent to be hospitalized. Then, it is likely that private counsel would advocate more strongly (and possibly more successfully) for respondent's commitment.

E. THE JUDGES' ROLE

In years past, civil commitment hearings were done without the trappings of typical judicial hearings. It was not uncommon that neither the hospital nor the respondent was represented by an attorney. When either or both of these attorneys was not involved in hearings, the judge needed to take a more active role in soliciting the information necessary to make a decision about commitment.

In an adversary system, such as that in Chicago, the arguments for and against commitment are to be presented by counsel. Judges have significant freedom to take different roles as they see fit. At one extreme, the judge can act entirely as a neutral fact finder, listening to the cases presented by the attorneys and depending upon them to establish all of the necessary facts upon which to base a decision. At the other extreme, judges can engage actively in asking questions and eliciting information from the parties in the case.

Chicago judges believe that they take the role of a neutral hearer of facts and depend on the assistant state's attorney and the public defender to establish the bases for and against commitment. Judging by our (admittedly limited) observations of hearings in Chicago, these researchers agree that the judges seem to take a neutral role, although they actively direct questions to witnesses. Some attorneys in

Chicago, however, express the opinion that Chicago judges take too active a role in the hearings, ask too many questions on their own initiative, and sometimes seem to be helping the assistant state's attorney make the case for hospitalization. Judges admit that they direct questions in court, frequently to solicit information that they think is important and was not sufficiently established in testimony elicited by the attorneys. The extent to which judges directly examine witnesses and whether such examination is slanted either for or against hospitalization undoubtedly varies from judge to judge and from case to case.

F. THE EXAMINER'S ROLE

Unless respondent waives the requirement, one psychiatrist or clinical psychologist who has personally examined the respondent must testify in person at the judicial hearing (3-807). The court also has the discretion to appoint one or more examiners to make an additional examination of the respondent and provide a report to the court and to the attorneys for the parties (3-803). With few exceptions, a single examiner testifies at a judicial hearing, because the respondent rarely waives the requirement for an examiner to testify and the court seldom appoints additional examiners.

Every examiner is supposed to begin an examination by explaining the purpose of the examination to the respondent and informing respondent that he or she has the right to remain silent and that any communications with the examiner may be revealed in a judicial hearing (3-208). If this information is not communicated to the respondent, certificates filed as a result of these examinations are nonetheless considered to be valid, but the examiners who prepared the certificates will not be allowed to testify in court. It should be noted that one examiner must testify at the hearing, that this examiner must have notified respondent of his or her right to silence, but that the testifying examiner need not necessarily be one of the two examiners who prepared certificates for the court.

Psychiatrists and psychologists testifying in court tend to present a neutral assessment of facts and opinions related to respondents' mental condition. Examiners do not feel comfortable advocating either for or against respondent's hospitalization and they are not expected to take this role. Examiners present a professional assessment of respondent's mental health. They also inform the court of the contents of official hospital records (which are admissible as evidence in court) that are relevant to respondent's case. Examiners are asked to testify about respondent's ability to provide for his or her basic physical needs, and although examiners always feel uncomfortable about answering such questions, they are also asked to assess the degree to which respondent may be dangerous to self or others.

It is part of both the literature and the lore of civil commitment that the examiner's testimony has a major influence on the judge's decision of whether or not to commit. While attorneys in Chicago believe this to be the case, judges express the opinion that they are not unduly swayed by the examiner's testimony. The observations of these

researchers in Chicago courts would tend to support the opinions of the judges. It is probably safe to say that an examiner's testimony would be extremely influential if an examiner testified that a respondent was not mentally ill or in need of hospitalization. When examiners testify in favor of hospitalizing a patient, however, our observations indicate that several other factors probably are equally influential in forming the judge's final decision: respondent's condition in court; his or her ability to testify coherently; substantial evidence of dangerous behaviors in which respondent has engaged; and whether or not resources can be identified in the community (other than a hospital) that can provide respondent the type of services or supervision that he or she seems to require.

The quality of testimony presented by psychiatrists or clinical psychologists varies considerably. Examiners who have had some courtroom experience are more comfortable in testifying, and understand the type of information that is expected from them. Many inexperienced examiners, however, find the judicial hearing to be a totally foreign environment and testify in a manner that pleases neither themselves nor the attorneys. Attorneys report that some examiners are resistant to providing information and force the attorneys to "drag the facts out" through a series of probing questions. Other doctors and psychologists habitually use technical language that is not acceptable by or understandable to the court. Others tend to report their findings in conclusory terms and do not understand the need for explaining the factual bases upon which these conclusions have been drawn.

Two different types of examiners testify at hearings in Chicago. Some are those who prepared a certificate on the respondent and who may or may not also be treating the respondent. The examiner also may be a psychiatrist or clinical psychologist who is representing a hospital, testifying for the hospital on some or all of the cases being heard at that time, and who is neither a treating physician nor responsible for any of the certifications. For lack of a better term, an examiner of this type might be called a "professional testifying examiner."

Having a professional testifying examiner seems to have both advantages and disadvantages. Attorneys representing respondent do not like this type of examiner because they feel he or she is not adequately familiar with the case. This examiner's appearance in court means in effect that the attorney will not have the chance to confront directly either a physician who is treating the patient or an examiner who produced one of the required certifications. Observations of many commitment hearings by these researchers, on the other hand, have shown that a professional testifying examiner usually makes a much better witness in court than the typical doctor. This type of examiner usually is more familiar with civil commitment law, knows how to present psychiatric testimony in a manner that is useful for the court, and testifies in a particularly understandable manner (especially in comparison with those foreign-born doctors whose testimony may be hard to understand because of language difficulties). Further, the professional

testifying examiner is more conscientious about honoring respondent's rights during the examination.

The professional testifying examiner is also useful from the hospital's point of view. Doctors do not like to testify in court because they do not see this as an appropriate role for their profession. Doctors point out that testifying in court introduces a significant disruption in their day, significantly reduces the amount of time they can spend with patients, and can badly harm a therapeutic relationship with their patient. The use of a professional testifying examiner avoids all of these problems.

G. WITNESSES

Petitioners are strongly encouraged to attend the judicial hearings as witnesses. Many hearings also will have mental health professionals (such as therapists, social workers, and nurses) in attendance to testify as needed. Judges strongly prefer to have witnesses present at all hearings to attest to the questionable behavior that has led to the commitment effort. Some attorneys express the opinion, however, that too many cases are heard in which the required witnesses are not present and the respondent is hospitalized anyway. Public defenders report that often an examiner will be the only witness at a hearing.

Hearings in Chicago were not very different in this regard from hearings observed by these researchers in other cities. If anything, the Chicago courts seem to be stricter about requiring the petitioner and other witnesses to be at the hearing. Other relevant witnesses in most cases are family members or close friends who will attend hearings (regardless of rules or judicial preference) if they are strongly concerned about respondent's either being or not being committed. The presence of mental health professionals (other than the examiner) as witnesses is unusual in hearings in other cities, except in recertification hearings in which hospital staff can testify about respondent's condition and behavior during the initial commitment period.

H. CONTINUANCES

For good cause shown (3-800 (b)), continuances can be granted for periods up to fifteen days on the court's own motion or on the motion of the assistant state's attorney. If requested by respondent, continuances may be granted for any period of time. Continuances are fairly common in cases in Chicago. Private attorneys and patient advocates express the opinion that too many continuances are granted; but those who are most frequently connected with the hearing (judges, assistant state's attorney, and public defenders) do not feel that the number of continuances is unreasonable or that continuances are often granted without good reason.

Judges have several reasons for granting continuances on their own motions. Sometimes, a judge feels that a respondent can receive enough treatment in the next fifteen days so that a commitment will not

be necessary. Judges believe they are doing a service to such respondents because it will avoid the stigma of having an involuntary commitment on their records. On the other hand, judges also may order continuances on their own motion when they feel that a particular respondent ought to be committed, but when witnesses who are critical to the case fail to show up in court.

The hospital occasionally asks for a continuance, for various reasons. For example, a doctor may be ill or otherwise unavailable to testify, and a continuance is requested so that the doctor will be available. If a patient has escaped during the prehearing period, the hospital may request a continuance while efforts are made to locate the patient. Or, the hospital may inform the court that the patient has requested voluntary admission but that the necessary papers have not yet been completed or forwarded to the court; a continuance is requested so that the voluntary application may be filed and approved. If a voluntary application has been made by the patient, the state's attorney may request a continuance if he or she feels the need to get more information to decide whether or not to object to the voluntary application.

Respondent may request a continuance for a number of reasons also. If a patient has contracted a physical illness, for example, the patient's attorney may request a continuance until the patient has recovered sufficiently to be able to attend the hearing. If respondent's attorney has been unable to communicate effectively with his client, he or she may request that the court grant a continuance while he or she attempts to prepare for the case more adequately. Or, if the respondent is currently in a violent state, a continuance is requested so that respondent can be treated and calmed down to the point where he or she can be present at a judicial hearing.

Only one practice with regard to hearings is cause for concern in Chicago. If a hospital (other than Read or ISPI) plans to request a continuance in a particular case, the hospital staff frequently do not transport the respondent to the hospital at which the hearing is scheduled to be held. The hospital requests the continuance with the expectation that it will be routinely granted. Public defenders point out that this practice deprives them of the ability to object to a continuance on the behalf of their clients. Quite simply, even if their objections were effective, the hearing probably would need to be continued to the next week anyway because sufficient time would not be available in which to bring the respondent from the other hospital to the place of hearing. The public defenders feel that hospitals should be required to transport respondents to the place of hearing in every instance, even if the hospital is requesting a continuance, unless this has been discussed with the public defenders in advance and they have no intention of objecting to the motion for continuance.

I. RULES OF EVIDENCE AND PROCEDURE

Civil commitment hearings are governed by the standard rules of evidence and civil procedure. Judges in Chicago enforce these rules, although some judges enforce them more stringently than others.

Attorneys who represent respondents tend to feel that the judges are too lenient in allowing hearsay testimony into evidence. Judges who tend to hold more of a "helping" attitude toward the mentally ill are more lenient in allowing testimony, in the belief that it is important for them to learn as much as they can about the respondents' need for mental health care.

Several types of evidence that commonly arise in civil commitment cases have become the focal point for some controversy in Chicago as well as in other cities. These include records from the hospital, information about previous psychiatric treatment and commitments, and information about pending criminal charges.

In Chicago, as in most other cities these days, it is commonplace and accepted that hospital records are allowed into evidence. These are records about the respondent made by attending physicians, nurses, and other ward attendants and therapists. Attorneys dislike the use of hospital records because it deprives them of the opportunity to confront and cross-examine the persons who are the sources of allegations that are damaging to their clients. Hospital staff, on the other hand, argue that enormous expense would be involved if their entire staff needed to be on call to attend hearings as witnesses in virtually every civil commitment case.

Information about previous psychiatric commitments and treatment is allowed into evidence at most hearings in Chicago. Judges and attorneys are aware that this information must be considered carefully, however. It is commonsense, as well as empirically established fact, that knowing about respondent's previous commitments makes a decisionmaker more inclined to order another commitment. The Chicago legal community seems to have established an informal working principle that psychiatric history evidence will be admissable to establish "psychiatric opinion" but not "legal fact." This seems to mean, in practice, that this evidence may be used to form diagnoses and plan treatment strategies, which obviously are important to the court. But, this evidence will not be accepted as a sufficient basis for concluding that the respondent currently meets the statutory definition for commitment, which must be established on the basis of recent behaviors and examinations. Hard-line "freedom" advocates argue that the introduction of this evidence at a hearing creates a harmful pro-commitment bias nonetheless, regardless of the court's distinction between what the information may or may not be used for. Mental health professionals, on the other hand, argue that it is impossible to provide an accurate diagnosis of mental illness or plan for treatment without referring to this information.

Attorneys also feel that judges tend to view the existence of pending criminal charges as evidence of a respondent's dangerousness. Such criminal allegations have not yet been proven in court and should not be taken as facts to support the contention that respondent is dangerous. Whether or not information relating to pending criminal charges is entered into evidence during the hearing, such information probably will come to the judge's attention because it is part of the

background information that the judge will have before him or her; it will thus influence the judge in any event. The admissability of such information into evidence is of greater importance, however, in the rare cases that a hearing is before a jury, which otherwise would not be aware of these pending charges.

Strengths and Weaknesses

A. LEGAL PROTECTIONS

The Chicago system for civil commitment, as has been noted in previous chapters, is noteworthy for its strong protections of legal rights. For example, hearings are mandatory in all civil commitment cases. This ensures that no respondent will be taken into custody and deprived of liberty without judicial review.

An important feature of the Chicago system for civil commitment is that hearings are held on every weekday. In other cities, hearings are held only once each week, for example, despite statutory requirements that would necessitate hearings on a more frequent schedule. Because hearings are held twice each week at Read and three times each week at ISPI, respondents have little trouble receiving a hearing within the five-day period prescribed by the statute.

Another strength is that respondent is almost always present at the hearing. For this reason, respondents have the opportunity to hear all allegations made about them and are able to assist in their defense to the maximum extent possible. Additionally, the judge always is able to see the respondent and need not rely solely on the reports of hospital and counsel about respondent's condition.

The public is allowed to attend civil commitment hearings. The public nature of court business is fundamental to the American system of justice. It guarantees that a person's liberty cannot be deprived in secret proceedings by processes that are not accessible to public scrutiny.

The Illinois statute is one of few in the United States that makes jury trials available by request of respondent. Although few jury trials are requested, the statute is strong in providing respondents the option of having their cases decided by a group of their peers.

The presence of the state's attorney to present the case for the hospital is a major strength of this system. Without a state's attorney to present the case, the judge and the hospital staff must assume the role of advocates rather than the more neutral roles with which they are more comfortable and accustomed. Further, the state's attorney represents the people of the state. This is both a legal strength and a weakness. The state's attorney is not compelled to represent petitioner or the hospital if he or she believes that people of the state would be served best if the respondent were not hospitalized. The statute thus allows the state's attorney the discretion to try the case in the manner that he or she deems appropriate. The system benefits from this because

legal resources are not expended on a case that does not merit it, in the state's attorney's opinion. To the extent that the system is designed to be adversarial, however, and the petitioner has initiated the case with valid cause and pure motive, it is arguable that the state's attorney should act in the role of a strong advocate without discretion to do otherwise. This role for the state's attorney thus can be viewed as a weakness for an adversarial system such as that used in Chicago.

Mental health examiners may testify at the hearing only if prior to the examination they have explained respondent's right to remain silent. This aspect of the law conforms well, in general, with ethical principles espoused by psychiatrists and related mental health professionals. The respondent must be alerted to the reason for the examination and have the opportunity to avoid incriminating himself or herself. A further discussion of the right to remain silent during a mental health examination will be presented below in Chapter XI.

Another important legal protection stems from the fact that petitioner is required to be present at the hearings. Because petitioner has initiated the involuntary commitment process, his or her testimony is of central importance to the judicial decision. It has been noted above that written information on petitions may not be entirely satisfactory. The presence of petitioner in court allows for a cross-examination of the petitioner by respondent's counsel to clarify his or her allegations on the petition.

The statute allows a respondent to get a continuance for any amount of time in order to strengthen his or her case. If respondent chooses to postpone the judicial hearing in order to prepare better for his or her defense, this can be done.

Another legal strength in this system is that rules of evidence and procedure are followed in the hearings. The use of rules of evidence and civil procedure ensure that hearings will be held in an orderly fashion and that the rights of respondents will be carefully protected.

One weakness in the Chicago system is the fact that court records are open to the public. Although court records are traditionally public documents, provisions have been made in other cities for sealing or expunging records of courtroom procedures that may be damaging to particular individuals and are not of sufficient value to the public to justify their public availability. Because of the stigma that society attaches to mental illness and involuntary commitment, it has been suggested by some Chicagoans that court records on these matters not be open to the public in order to protect the privacy of the individuals involved. Further discussion of this issue will be undertaken below in Chapter XI.

Neither the certifying examiner nor the treating physician is required to testify at a hearing. From an attorney's perspective, this is a weakness in the Chicago system. An examiner, who may not be one of these two individuals, will necessarily testify about the medical certificates and hospital treatment as reflected in the written records.

Without the use of a subpoena, respondent's attorney may not be able to cross-examine psychiatrists and psychologists whose allegations are instrumental in respondent's hospitalization. Similarily, the admissibility of hospital records as evidence denies respondent's attorneys the opportunity to confront and cross-examine witnesses about evidence that is damaging to respondent's case.

In a previous chapter, it was considered a weakness (from a legal perspective) in the system that certifying examiners could have available to them information about previous psychiatric care and commitments. Through much the same reasoning, it is considered a weakness in the system that records of previous psychiatric treatment are admissible in a hearing. The introduction of this evidence may strongly bias the judge's perception of the case. Whether or not a person is dangerous to self or others or unable to care for basic physical needs should be decided primarily from evidence of recent behaviors, not on the basis of information in a previous psychiatric file. And, while it is true that information from previous psychiatric involvements may be helpful in forming a differential diagnosis of illness, such information is seldom critical to the gross diagnostic decision of whether or not the patient is mentally ill, which is all that is required by the statute.

A final legal consideration is that a two-week continuation can be obtained easily by the court or the hospital. It is appropriate that continuances be allowed on the motion of the court or the hospital under some circumstances. Based upon the required showing of good cause, these occasions should be rare, however, and the reasons should be justified strongly in light of the fact that respondent will be detained for an additional two weeks without a judicial hearing. Although the public defenders in Chicago do not believe that continuances by the court or the hospital are used in excessive quantity, many private attorneys feel that continuances are granted too easily and too frequently.

B. PROVISION FOR TREATMENT

A major advantage of the Chicago system is that hearings are held at hospitals. Respondents who face civil commitment proceedings are understandably anxious and upset. Many of them find it difficult to cope with the legal complexities of their situations and are somewhat more comfortable in a hospital setting. Considerably less trauma is involved for patients who are already at the hospitals where the hearings are held and who thereby can avoid transportation difficulties.

Chicago judges are concerned with proper decorum in the courts, which is important for respondent's well-being. An orderly and attentive court will assure the respondent that his or her case is being considered carefully and that thoughtful decisions have been made in his or her best interest. A disorderly court environment, on the other hand, will add to the level of anxiety and paranoia with which such people frequently enter the hearing.

From a treatment perspective, it is advantageous that judges solicit information actively during the hearing. Occasionally, the case

for or against hospitalization will be made not on the basis of the patient's needs, but on the varying abilities of the attorneys. In the interest of complete fact-finding, a judge who suspects that some important information may not have come out during testimony, may take the opportunity to directly question witnesses and elicit the information.

Some judges have asked for continuances in order to allow a person to recover and be discharged in order to avoid the stigma of involuntary commitment. The fact of involuntary commitment can influence many factors about one's life, such as employment and family matters. If an acute episode of mental illness can be treated successfully within a period of two weeks, it will be to the respondent's benefit that the case can be dismissed and a period of involuntary commitment will not be authorized.

Two factors about the Chicago system may work adversely to affect respondent's well-being: respondent is always present at the hearings and the public is allowed to attend the hearings. It has been argued that respondents can suffer emotional and mental damage by the experience of listening to relatives, friends, and doctors testifying about them. Families fear that respondent's relationship with them will suffer as a result of the courtroom experience. Examiners who are also treating physicians believe that their testimony in court with respondent present can significantly interfere with their ability to establish a good therapeutic relationship. The presence of the public in the courtroom also can be a source of embarrassment to the respondent and may worsen his or her condition. It should be noted, however, that respondent's presence at the hearing may be waived by respondent's attorney if it appears that it would present substantial risk of serious harm to respondent. Similarly, respondent's attorney can request that the hearings be closed to the public for good cause shown. Thus, these disadvantages are not serious ones.

In contrast to the opinions cited in the previous paragraph, some doctors feel that respondent's presence at the hearing is beneficial from a treatment perspective. They feel that the courtroom experience is frequently a useful precursor to successful treatment. First, it demonstrates to the respondent that he or she has not been confined surreptitiously by the doctor or family; the obvious symbols of the justice system (judge, bailiff, courtroom) help confirm that the confinement is an official act of the state. Next, patients witness the fact that a "wise judge" impartially determines that treatment is needed, and respondents may be strongly influenced by orders or advice given to them directly by the judge. Finally, the hearing brings out the facts that are the basis for commitment. The respondent hears about his or her behavior that is considered unacceptable, which can be a useful starting point for shaping respondent's behavior into more socially acceptable forms.

C. SOCIAL BENEFITS

An important social benefit is that hearings are scheduled on a regular basis in Chicago. Having set days for commitment hearings at the

hospitals makes it possible for the court and hospital staffs to schedule their calendars and minimize disruptions and costs.

Society clearly benefits from the fact that the public is allowed at hearings and court records are public documents. By opening this process to public scrutiny, concerned individuals can monitor this liberty-depriving process, and researchers have access to information through which this process might be understood and improved.

It was mentioned above that both legal strengths and weaknesses can be identified in having the state's attorney represent the people of the state. From a social point of view, this is entirely advantageous, however. The state's attorney has the discretion to minimize the use of his or her time and the possible use of treatment facilities by not being required to advocate strongly for hospitalization in all cases. Using his or her judgment, then, the state's attorney has some discretion in channeling society's legal and treatment resources to those cases that seem to need them most.

Society also benefits by the practice of allowing hospital records to be used at the hearings. By allowing critical evidence to come in through hospital records, it is unnecessary for hospital staff to take time away from patients and other important hospital activities in order to testify at hearings.

Several aspects of the civil commitment process in Chicago might be considered weaknesses from a societial perspective, primarily because they are costly to implement. For example, having mandatory hearings is more costly than a system in which all cases do not result in judicial hearings. Jury trials, when they are held, incur significant costs and also introduce delay into the process. The use of an assistant state's attorney at every hearing also is a significant cost, as is the involvement of mental health professionals (other than the examiner: e.g., nurses and ward attendants) as witnesses. All these factors, of course, have countervailing values in contributing to legally rigorous procedures to protect the liberty interest of the respondent. In many other systems, the judgment has been made that the legal benefits are not worth the social costs, and some or all of these system characteristics have not been used.

Recommendations

VIII.1 (*) Judges should further emphasize courtroom order and decorum. Because of the sensitivity of this proceeding and the respondent's condition, special care should be taken to ensure that the courtroom environment is quiet and orderly and that careful attention is given to witnesses as they testify.

VIII.2 (**) Judges should not seek primary information about dangerousness from examiners. Rather, dangerousness should be inferred from specific threats or overt acts of respondent, reported in testimony given by petitioner and other

witnesses. Psychiatrists, psychologists, and social workers receive no special training in predicting dangerous behaviors. Empirical studies have shown that predictions of dangerousness are notoriously poor and are no better when done by professionals than by lay individuals. Consistent with an earlier recommendation that petitioners be encouraged to cite a specific overt act in support of the contention that respondent is dangerous, judges should seek evidence for dangerousness that is based on threats or specific behaviors in which respondent has engaged in the recent past that are, per se, dangerous. It is possible, of course, that an examiner will be able to testify about dangerous behaviors that he or she has observed directly. Most likely, however, respondent's behavior will be subdued physically or medically in the time that he or she is seen by the examiners. Further, occasions will arise when doctors will testify convincingly that respondent is potentially dangerous, even in the absence of an overt threat or dangerous act. For most cases, however, the petitioner and other witnesses should be required to testify about specific dangerous behaviors they have observed respondent engage in, and these specific behaviors (not psychiatric testimony) should be the primary basis for deciding whether or not respondent is dangerous to self or others.

VIII.3 (***) An orientation should be given to inexperienced examiners who are going to testify at a hearing, prior to the time that the hearing begins. Testifying in court is highly distasteful to many mental health professionals and is an activity at which they are not usually adept. Doctors, who usually are accorded high respect and unquestionable authority in medical matters, are not accustomed to being queried and badgered about their conclusions and forced to justify the process by which those conclusions were reached. Doctors who testify in these cases frequently have had no formal training about legal procedures and do not appreciate either what is expected of them or the process through which it will be obtained. A short meeting with doctors prior to hearings and an orientation to the process may be of considerable benefit to everyone involved and probably could be done quickly and inexpensively.

VIII.4 (**) Respondent should be required to be brought to every hearing, even if a continuance is to be requested by the hospital. As pointed out earlier, hospitals may neglect to transport a respondent to the hearing if the hospital intends to request a continuance in the case. This practice makes it impossible for the public defender to object to the request for continuance because the hearing could not proceed without respondent's presence. If it would be harmful for respondent to be taken to the hearing, or if the reason for the continuance is so clearly legitimate, respondent's presence at the hearing in such circumstances could be waived if the

hospital contacted the public defender in advance and received agreement that a continuance was desirable.

VIII.5 (**) Information on previous psychiatric treatment should be admissible into evidence at the commitment hearing for purposes of diagnosis and treatment planning, but should not be accepted as sufficient evidence that respondent meets the criteria for commitment. The basis for this recommendation has been discussed above. Briefly, it is noted first that this information strongly biases decisions in favor of a commitment. Evidence of dangerousness preferably should not depend on information gleaned from the records of previous psychiatric hospitalizations but should depend upon behaviors observed in the recent past and reported to the court by petitioner and other witnesses. (Because of some appellate court cases, an informal norm in Chicago is that respondent's actions are considered relevant if they occurred within the last two years or so.) Finally, the statutorily required determination of mental illness, as distinct from a differential diagnosis, rarely necessitates information from previous psychiatric hospitalizations. On the other hand, it is acknowledged that information about previous psychiatric treatment serves an important and valid function in the hearing. This information is absolutely essential to an accurate diagnosis of the exact nature of the mental disturbance, and to the formulation of an effective treatment plan. For these reasons, this information must be admissible into evidence at the hearing, but used correctly. A respondent should not be committed substantially on the basis of psychiatric history, because this makes it virtually impossible for the respondent ever to avoid being committed again, once previous behaviors and events have become sufficient to satisfy the commitment criteria. The respondent should be committed only because his or her current condition warrants it. But a complete diagnosis and plan for respondent's treatment must be made on the basis of psychiatric history as well as the respondent's present condition.

CHAPTER IX. DETERMINING TREATMENT

Description

This chapter considers information raised during judicial hearings that is relevant to the type of treatment to which a respondent may be ordered. For the most part, this information is important only if a person is determined to be a proper subject for involuntary admission. Much of the information is raised in Chicago hearings, however, concurrently with evidence bearing on the question of whether or not to commit.

A. RESPONDENT'S CAPACITY

The Illinois statute makes it clear that adjudication on the question of involuntary civil commitment shall have no bearing on conclusions about respondent's legal competency (2-101). Involuntary commitment in no way presumes that a patient lacks the capacity to make decisions about treatment. The questions of competency or capacity to make treatment decisions are not raised during civil commitment hearings and, if raised at all, must be taken up in separate hearings. Generally, these issues are raised only within the context of guardianship hearings, which have sometimes been used as a means of procuring voluntary treatment for patients who are incapable of providing voluntary consent for treatment that they require.

B. CONSIDERING LESS RESTRICTIVE ALTERNATIVES

In civil commitment hearings, least restrictive alternatives (LRAs) can be considered in two different ways. The first possibility is to think of LRAs essentially as a threshold: Is there a way to administer treatment in a setting that is less restrictive than inpatient hospitalization? If the answer to this question is yes, then respondent's case is dismissed and no commitment is ordered. The second possibility is to consider LRAs as a commitment alternative: given that a person meets the statutory criteria for commitment, what is the least restrictive manner by which treatment can be provided? The Illinois statute requires a consideration of LRAs in the second manner, as a commitment alternative (3-811, 3-812). In practice, judges also consider LRAs in the first sense, as a threshold, and may dismiss a respondent's case if evidence reveals that an outpatient alternative, which respondent is likely to take advantage of, is available to the respondent.

The question of less restrictive alternatives is raised invariably at every hearing, frequently in a pro forma manner and rarely with thoughtful, careful consideration. Most often, it arises first in response to a question by the assistant state's attorney to the hospital examiner. The examiner is asked whether less restrictive alternatives have been considered for respondent and whether or not such LRAs are appropriate. Hospital staff usually respond by saying that LRAs have been considered and are inappropriate, without providing any detail about what specific LRAs had been raised as possibilities or the reasons they

were ruled out as inappropriate. Most frequently, the hospital's reasoning in testimony does not flow from an analysis of existing LRAs, but rather results simply from an examiner's opinion that a person must be hospitalized, thereby rendering discussion of LRAs irrelevant.

It may be recalled that the statute requires a comprehensive physical and mental examination and social investigation for all respondents who are considered unable to care for their basic physical needs (1-119). The primary purpose of the "pre-admission" examination is to consider possible community alternatives to hospitalization. If these examinations are performed as required, the hospitals should be able to present detailed information about a patient's needs, community resources that might be appropriate, or specific reasons why resources in the community cannot provide the necessary care.

The nature of Chicago's mental health system explains (at least in part) both why less restrictive alternatives are not often considered extensively during commitment hearings, and why caution is needed to be sure that they are considered. Because of the effective network of outpatient clinics in Chicago, people who might benefit from treatment alternatives that are less restrictive than inpatient hospitalization are likely to receive treatment from the clinics. Thus, most people who reach judicial hearings in Chicago are seriously ill and need inpatient care. For most hearings, then, it probably is safe to suppose that LRAs are inappropriate and that a careful investigation of LRAs is not a useful expenditure of personnel resources (although it is statutorily required, as discussed above). The inherent danger of this situation is making the assumption for any particular respondent that, because the system works as it does, and because he or she has reached this stage of the process, this respondent must be seriously ill and needs to be hospitalized. The purpose of the hearing is to establish whether or not that is so--yet the Chicago system practically invites that conclusion as an assumption. Thus, because of Chicago's mental health system, it is easy to ignore LRAs at a hearing, but it is simultaneously important to consider them carefully.

The most compelling less restrictive alternative is the placement of the respondent into the care of family or close friends. Our observations around the country suggest that the state's attorney generally will raise this possibility when it is not likely (thus, bolstering the need for hospitalization), while the public defender generally will raise the possibility when it is likely (thus bolstering the case for release). The presence of family or friends who are willing to provide the necessary care is an influential inducement for the judge to dismiss the case or, in some cases, to commit the person into the care and custody of these people.

Public defenders in Chicago express the opinion that more attention could be given to community-based less restrictive alternatives than is done in most cases. While the responsibility to consider treatment options is fixed by statute on the mental health facility director (3-810), respondent and respondent's attorney have a greater interest in arranging alternative resources. The public defenders make

an effort to determine whether or not LRAs would be appropriate in a particular case but they are severely constrained in this effort by their taxing caseload. Public defenders would like to see some social work staff specifically designated to do a careful investigation of less restrictive alternatives for mental health cases. Such social work staff could be under the authority of either the Department of Mental Health and Developmental Disabilities, the Guardianship and Advocacy Commission, or the court. Public defenders also point out that a more efficient use of resources would be realized by seriously exploring LRA possibilities only for those respondents who are found subject to involuntary admission. Because the statute structures LRAs as a commitment option, not as a threshold, an investigation of LRAs technically is unnecessary if the respondent is not subject to involuntary admission. Background information about respondent still could and should be compiled prior to a hearing; but a detailed investigation of community treatment resources would be done only if it were determined that respondent were in need of them.

Less restrictive alternatives are an important factor in cases in which respondent is not seriously mentally ill and full inpatient care is not required. It was reported to these researchers that LRAs are most thoroughly discussed in cases where the judge seems ambivalent about how to decide the case. Defense attorneys have a slightly different perspective and report that LRAs are considered carefully when the assistant state's attorney has failed to make the case for hospitalization strongly, but the judge feels that treatment really is needed. Clearly, the judge will be ambivalent and/or the state's attorney will have a hard time with his case when respondent is not seriously ill -- where inpatient hospitalization is not required but some mental health treatment seems to be called for. These are precisely the cases in which placement in a less restrictive alternative should be examined thoroughly and is the preferable mode of treatment.

Less restrictive treatment alternatives are attractive in concept but extremely difficult to implement in fact. Too few community-based outpatient treatment facilities exist to meet the needs of the seriously ill in Chicago and those that exist are typically providing services at capacity. Hospital mental health staff have some knowledge of community LRAs, but judges and attorneys have little knowledge of them. It has been suggested that both the mental health and the legal communities involved in involuntary commitment need education about LRA resources in the community and access to updated information about the capacity of such programs to accept new cases.

Community-based LRAs are hard to establish and seem to be decreasing in number. Appropriations for mental health treatment services have been decreasing in recent times. The general public does not respond well to having "mental cases" walking the streets or, worse yet, living in the house next door.

Another problem that has bothered judges and community-treatment staff about commitment to LRAs is the lack of any enforcement mechanism. If a respondent is committed to receive treatment in a community-based

LRA, and if he or she fails to attend treatment sessions or take medications, what is to be done? The lack of any apparent treatment incentive or enforcement mechanism has made many judges reluctant to commit a respondent to a community-based LRA and has made the LRAs hesitant to accept a patient who is under a commitment order.

Members of the legal community may overlook the fact that the concept of the least restrictive alternative can and should be applied within a hospital setting as well as to community-based outpatient resources. Hospitals have a variety of treatment programs and alternatives that span a dimension of restrictiveness: home visiting privileges, grounds privileges, open wards, locked wards, and seclusion rooms are examples. Traditionally, the hospital has been viewed as a unitary treatment option that a judge might order; responsibility for treating the patient in the least restrictive manner subsequently fell to hospital authorities and their mental health staff. Illinois statute authorizes the court to order the least restrictive alternative for treatment that is appropriate for a respondent (3-811), however, and no reason is immediately apparent why it would be inappropriate for the court to consider and order the least restrictive alternative within a hospital setting as part of the judicial commitment. Courts have been reluctant to order specific types of treatment, rightfully so, and this discussion is not meant to bring that into question. But courts and statutes have directed treatment facilities with regard to allowable restrictions on patients, which is the concern of these comments. Further, this discussion should not be read as an implication that hospital authorities and mental health staff have in any way denied patients of the right to treatment in the least restrictive manner. It is meant only to point out that the legal community frequently overlooks the dimension of restrictiveness in treatment alternatives available within a hospital setting and considers less restrictive treatment alternatives only in the dichotomous relationship of inpatient hospital care versus community-based outpatient treatment.

C. PRESENTING A TREATMENT PLAN

The Illinois statute is unique in that it requires a formal treatment plan to be presented by the mental health facility to the court during the judicial hearing. The plan is to describe respondent's problems and needs, the treatment goals, proposed treatment methods, and a projected timetable for their attainment (3-810). Other states in which these researchers have observed hearings have not required a formal presentation of a written report for the court. These other states depend upon either finding the information in hospital reports submitted to the court or in having the information elicited during testimony from the examiner or treating physician.

The statutory intent expressed in the Governor's Report was that a treatment plan be presented as a means of considering the least restrictive manner by which treatment might be given. Implicitly at least, it is clear that if no effective treatment can be anticipated for a respondent then the state will have failed to make its case for respondent's commitment. A related effect of requiring treatment plans

to be presented at the commitment hearing is important, if subtle; once a hospital has submitted a plan documenting a respondent's need for treatment and the manner in which such treatment will be provided, this effectively eliminates the problem (that does occur in other systems) of judges committing patients to a hospital only to have the hospital decide that the respondent is not a fit case for treatment and refusing admission.

In theory, the presentation of a treatment plan at the initial hearing enables a respondent to defeat the state's case by challenging the appropriateness or utility of the proposed treatment. This does not appear to happen in practice, however, although it might occur if more respondents employed independent examiners who would testify with regard to the quality of the treatment plan.

Mental health professionals generally are not enamored of the requirement for a treatment plan at the initial hearing. They comment that a treatment plan, which is based upon less than five days of time with a patient who may be in an acute psychiatric crisis, is likely to be highly tentative. Working within an environment in which patients have a broad right to refuse treatment, it may be difficult to say whether, when, and how specific treatment modalities will be implemented. The result in Chicago has been a pro forma conformity with the requirements of the law. Physicians and attorneys in the Chicago system agree that treatment plans submitted during initial hearings are broad, shallow, brief, general rather than specific, and characterized by one person as "boilerplate." Treatment plans do not form the basis for a useful challenge to a commitment because their contents are so broad as to be generally accurate, although more or less meaningless.

Despite the generally unhelpful final product that is sent to the court, people in the system are not seriously opposed to the presentation of treatment plans at the hearing and go so far as to suggest that they may, indeed, serve a purpose. The requirement of filing a treatment plan forces hospital staff to confront the question of treatment choice and feasiblity for each respondent. The discussion of treatment plans in the courtroom setting, even in the generalistic terms that they present, has value in educating lawyers and judges about the types of treatment that are available in the hospitals, the time periods in which treatments might be effective, and the nature of "cures" that may be expected from these treatment modalities.

Illinois statute also specifies that a treatment plan must be revised after 30 days of care and submitted to the court. The court is then to review this document to determine whether "the patient is benefiting from treatment," with the authority to discharge the patient or rehear the case if the court is not pleased with the report (3-814). In practice, although the 30-day plans are filed with the court, the court almost never reviews them. Another section of the Illinois statute (3-209) requires the treatment facility to update each patient's treatment plan at least every 30 days. Each 30-day plan must include an assessment of the patient's needs, recommended services, goals of the services, a timetable to accomplish the goals, and designation of

responsible professional staff. In theory at least, these documents can become important pieces of evidence in discharge hearings or in hearings for patient recertification. The file of successive 30-day plans can be examined by the court to determine whether the patient has received treatment and whether this treatment has had any noticeable success.

D. JUDICIAL TREATMENT OPTIONS

Before ordering a person into any type of treatment, Illinois judges must first determine that respondent is subject to involuntary admission, in accordance with the criteria specified in the statute. The statute gives judges no authority to order treatment of any type for individuals who are not found to meet this basic criterion.

Recall that with few exceptions, people in Chicago are committed as "emergencies," which means that they allegedly are in need of immediate hospitalization. In practice, because of the formal and informal screening mechanisms, nearly all those who reach the stage of having a judicial hearing are really quite ill. Thus, as pointed out earlier in this chapter, it is not surprising and probably is appropriate that most respondents are committed to hospital inpatient facilities.

By broad statutory authorization, virtually any type of mental health facility or hospital with a mental health unit that is willing to accept respondent on order of the court is an appropriate institution for receiving such patients. Most of the judicial commitments are, of course, to public facilities and few respondents are committed to private hospitals.

Nonetheless, the statute certainly anticipates (perhaps even prefers) the possibility that respondents will be committed to less restrictive outpatient facilities. The judges must find respondent subject to involuntary admission, not involuntary hospitalization. Statute states, "If the respondent is found subject to involuntary admission but not in need of hospitalization, the court may order him admitted to a program of alternative treatment" (3-812(a)). Such less restrictive alternatives, however, must be able to provide appropriate treatment that is both humane and adequate for the respondent's condition (3-812). A less restrictive treatment alternative that is mentioned specifically in the statute is commitment of respondent into the care and custody of another person.

Judicial orders of commitment are only orders binding the respondent into the care of an institution (or person). Judges have not attempted to write orders that specify treatment modalities or restraints for the institution. Institutions have retained full discretion over the manner in which the patient is to be treated once he or she is sent to the institution. While this practice is widely considered appropriate -- essentially leaving the commitment to the judge and the treatment to the doctors -- it has been remarked that a judicial order regarding specific treatment, if following a treatment plan submitted by the hospital, is not out of the question. This chapter also has noted already that judges

perhaps ought to inquire more actively into the hospital's plans for treating the respondent in the least restrictive setting within the hospital.

Judges in Chicago report that sometimes they would like to have the authority to commit respondents to community-based outpatient programs without needing to find the person subject to involuntary admission. This desire is motivated by their feeling that many people come before them who need help, and it is unfortunte to be required to wait for their situtations to deteriorate badly before they can be ordered for treatment. It is our opinion that the legal principles by which the statute is designed are sound, however, and properly constrain the judges' authority to order treatment involuntarily. Further, this statute is remarkably fluent in providing judges options to order treatment, when it is needed, in a manner that will be most effective for respondent and most protective of his or her liberty interests. Thus, in our opinion, the Illinois statute seems excellent as written and no changes in this regard would be warranted.

The Chicago court community has devised an informal process that has come to be called "voluntary outpatient treatment." The process has no formal legal basis and is purely independent of any statutory prescription. The process is invoked cooperatively by the judge, the state's attorney, and the public defender for people whom they consider to be "borderline," i.e., who seem to need some help but not seriously enough to meet the statutory criteria of "subject to involuntary admission." To invoke the process, the public defender informs the judge at the hearing that the respondent would like to receive voluntary outpatient treatment. The judge agrees. The case is not dismissed, but the person is not committed. The respondent agrees to enter outpatient treatment and report back to the court after 90 days. A request is made for a 90-day progress report from treatment staff at the outpatient facility. If good progress is made, the case will be dismissed after the 90-day period. If, at any time, no progress has been made, the petitioner still wishes to press the case, and the respondent's condition seems to warrant it, the commitment process is re-initiated.

Judges and attorneys have had good success with voluntary outpatient treatment, although they admit candidly that its legal standing is completely uncertain. The informal arrangement never has been challenged legally. The court has no apparent legal authority to order the "voluntary" treatment, or even to participate in it in any manner. Nor does it have apparent legal authority to suspend the commitment proceeding, or request the respondent to report back to the court in 90 days, as is done. Nonetheless, the informal process has worked well for several respondents and is becoming a popular and regular addition to judicial treatment options in Chicago.

Strength and Weaknesses

A. LEGAL PROTECTIONS

One important characteristic of the Illinois statute is its specification that a respondent is not presumed incompetent without a separate judicial hearing. Solely as a result of civil commitment, a respondent does not lose any of his or her civil or personal rights. He or she retains the legal ability to vote, write a will, spend money, and other related activities unless a separate hearing is held to determine whether these rights should be curtailed. Respondent also retains the right and capability to refuse treatment unless a separate hearing is held to establish that respondent lacks the capacity to make treatment decisions.

The Illinois statute is one of several across the country that treats the concept of less restrictive alternatives not as a threshold but as a commitment alternative. This is an advantage because judges are authorized to commit respondents to appropriate less restrictive treatment alternatives. Commitment to the least restrictive treatment alternative minimizes the deprivation of liberty that is cast upon respondent involuntarily. Without authorization for judges to commit to LRAs, respondents must simply be released if LRAs exist.

Another legal strength is the requirement that a formal treatment plan be presented at the hearing. Assuming that a treatment plan is prepared carefully, it should demonstrate that the treatment facility can and will take positive steps to improve the person's condition rather than serve only as a means of custody. It should demonstrate what is to be done to the patient that makes a less restrictive alternative impractical and a more restrictive alternative unnecessary. The treatment plan, submitted by the proposed receiving institution, is in essence a guarantee that if the court commits the respondent, an institution stands ready to accept respondent and provide appropriate treatment.

At least in theory, another excellent point in the mental health code is the requirement that a revised treatment plan be submitted to the court within 30 days after a person has been committed. This provision guarantees that no respondent may be institutionalized for any more than 30 days without his or her case being reevaluated by the court. If the treatment facility is not following the treatment plan that had been proposed at the hearing, if the treatment has not resulted in any positive change for respondent, or if respondent's condition has improved considerably, the court is authorized to change the commitment order or discharge the patient.

Once a patient has been committed, a treatment plan is to be updated at least every 30 days. This requires that the treatment facility establish a record of treatment activities and the patient's progress throughout the commitment period. This information can become the major evidence in subsequent hearings or legal disputes involving the

patient. For example, these records can be critical if the patient petitions the court for a discharge hearing or, if at the end of a 60-day or 180-day commitment period, the hospital petitions the court to retain respondent in treatment.

A deficiency in the Chicago system is the lack of any means by which to enforce an order of commitment to a less restrictive alternative. If a respondent is ordered to outpatient treatment at a community facility, and if the respondent fails to participate actively and constructively in the treatment program, no legal recourse is pursued. This is one reason why judges hesitate to order treatment in less restrictive, community outpatient facilities.

The Chicago system suffers because public defenders are unable to give less restrictive alternatives sufficient attention. Public defenders do not have enough time thoroughly to investigate LRAs that might be appropriate for their clients. For the most part, they are forced to accept the hospital's position that it has done a thorough and careful investigation of LRAs, although it is unusual for an attorney for one party in a civil suit to trust the assertion that staff for the other party has acted in the best interests of the attorney's client.

It is generally acknowledged that treatment plans presented at hearings are not particularly well prepared. The treatment plan is, in theory, important documentation that respondent's commitment is appropriate and that the anticipated treatment is the best that could be provided. As the system has operated in Chicago, however, treatment plans presented at hearings fail to provide this documentation in any meaningful way and thereby deprive the respondent of a meaningful opportunity to challenge the plan prior to his or her being subjected to it.

Similarly, while the theory is good, the Chicago system suffers from a lack of review of the 30-day treatment plans that are filed with the court. Arguably, some advantage exists to having these plans filed even if the court fails to review them. The mere fact that the hospital must submit the plan conceivably encourages the hospital to act toward respondent as this statutory provision intended. The statute clearly directs, however, that "the court shall review the treatment plan." Unless the court establishes a review mechanism, as the statute directs, it is impossible to know for sure whether this provision of the statute is functioning as it was intended to.

B. PROVISION FOR TREATMENT

The judge's authority to order commitment to a less restrictive alternative is not only a legal strength but of significant value in the provision of treatment as well. Judges might hesitate to order treatment for respondents for whom hospital inpatient care might not be desired, even if it were technically appropriate. Rather than being forced to release the respondent, thereby providing no treatment whatsoever, judges in Chicago can commit respondent to treatment in a more appropriate setting.

Similarly, the statutory requirements regarding treatment plans also provide strengths from this perspective as well as from the legal perspective. The preparation of a treatment plan and its presentation to the court after a period of 30 days of commitment ensure that treatment will be appropriate and of sufficient progression to justify its continuation. In theory, at least, the quality of treatment should benefit from careful planning and systematic review.

The weaknesses in the system, as might be suspected, derive from the fact that the statutory requirements are not fulfilled in practice. Less attention is given to LRAs than could or should be done and few commitments to less restrictive, community outpatient facilities actually occur. Treatment plans submitted to the court at hearings are admittedly shallow, and treatment plans submitted after a period of 30 days admittedly are filed away in drawers with no review. Insofar as these statutory provisions present the potential for contributing to the better treatment of patients in Chicago, the system suffers from their lack of effective implementation.

C. SOCIAL BENEFITS

Society could benefit greatly from the requirement to investigate less restrictive treatment alternatives and to present a treatment plan at the judicial hearing. The implementation of these requirements would ensure that social resources were being used in a cost-effective manner, that expensive inpatient facilities were available only to those actually in need of hospitalization, and that no person would be held at taxpayers' expense unless some appropriate treatment were planned and delivered.

A problem in the Chicago system results from the enormous amount of hospital staff time spent in preparing treatment plans for the court. Hospital staff time is at a premium; time spent preparing reports is time that is taken away from direct contact with patients and other important therapeutic activities. Treatment plans are prepared for all patients who go through hearings, including those who are released and whose treatment plans therefore go unused. Treatment plans prepared after 30 days of commitment apparently serve no purpose other than to meet the requirements of law, since they are not reviewed by the court. Treatment plans produced only to satisfy statutory requirements most likely are less effective and a relatively less utilitarian use of hospital staff time than those that would be done by treatment staff, for treatment purposes, without the legal compulsion.

Recommendations

IX.1 (**) More attention should be given to less restrictive treatment alternatives during judicial hearings. In many hearings, the consideration of less restrictive alternatives is brief and superficial. Hospital staff may simply testify that respondent is in need of inpatient treatment and that no less restrictive alternatives are appropriate or available.

It should be remembered that merely because a respondent could benefit from hospitalization, less restrictive alternatives are not necessarily inappropriate. During the hearing, testimony should be elicited as to which specific outpatient treatment alternatives were considered, why these were rejected, or why the respondent is generally unsuited for an outpatient treatment program. If inpatient treatment is definitely required, attention should be given to whether or not the treatment plan submitted by the hospital specifies the least restrictive treatment that can be devised for the patient within the hospital setting. The respondent's right to treatment in the least restrictive manner applies both within a hospital and in the relation of hospitals to other facilities.

IX.2 (***) In spite of all the difficulties of presenting treatment plans within the first five days of treatment, treatment plans presented to the courts during commitment hearings should be as specific as possible regarding respondent's condition and should discuss the possibility of less restrictive treatment alternatives within the hospital. It is clearly difficult for hospital staff to provide a treatment plan that is anything more than tenuous for a patient who has just been admitted for mental treatment. Nonetheless, a treatment plan is required as part of the commitment proceeding. The intent of the statute in requiring a treatment plan was to encourage hospital staff to consider less restrictive treatment possibilities and the availability of appropriate treatment. Although reports from the legal and mental health communities indicate that treatment plans at commitment hearings are seldom reviewed as envisioned by those who drafted the statute, the mere exercise of preparing and submitting the treatment plan appears to be of value even in its present practice. An effort should be made to make treatment plans more specific to respondents and to give added consideration to alternative treatment possibilities within the hospital setting. We remain aware, though, that little improvement over the present practices may be possible.

IX.3 (**) Consideration should be given to a practice whereby detailed treatment plans and considerations of less restrictive alternatives be undertaken only for patients who are committed. For those respondents who are not committed, the staff time spent in preparing detailed treatment plans and investigating less restrictive alternatives (outpatient or inpatient) is essentially wasted. Staff time could be used more efficiently if these efforts were undertaken seriously immediately following a court-ordered commitment. Illinois statute allows a period of seven days during which an institution may transfer a patient without giving two weeks prior notice. This seven-day period could be used, for example, to give these matters careful consideration and to transfer the patient subsequently to an appropriate treatment

facility or modality. Assuming that no unusual treatments were recommended and that the transfer were to an equally or less restrictive facility, no judicial review of the process would be needed; but a system for judicial review could be established if the revised treatment plan necessitated new treatment strategies or more restrictive confinements.

To some extent, this recommendation is contrary to the first recommendation made in this chapter (i.e., that more attention be given to LRAs). If the first recommendation were implemented, and if the hospitals complied fully with the statutory requirement regarding a comprehensive pre-admission examination and social investigation (1-119), this recommendation would be unnecessary. The present practice, though, in which too little attention is given to LRAs probably is caused (at least in part) by a paucity of resources. The present recommendation is based on the theory that if resources are strained, a more efficient use of them would be realized by examining LRAs only for those respondents who are committed. Prior to the hearing, social investigations would be done only for the limited purpose of determining whether or not involuntary treatment were required, not for exploring thoroughly the treatment options that would be available.

IX.4 (**) Judges and attorneys should become more aware of community-based treatment programs that are available as less restrictive alternatives. Currently, only the hospital staff seems to be fully informed of treatment programs available within hospitals and throughout the community. Because respondent seldom has an independent examiner, no one from the psychiatric and mental health community advocates solely for the respondent in considering respondent's appropriateness for a less restrictive treatment program. A heightened awareness by judges and attorneys of the types of treatment programs available in the Chicago area, the way they function, and the types of people who are eligible to receive their services would help implement the statutory concern with LRAs.

IX.5 (*) A system should be established so that current information is readily accessible about community-based, less restrictive treatment alternatives (LRAs) and their capacity to accept new cases. Community treatment facilities handle an enormous caseload and currently are receiving decreasing amounts of funding from government sources. It is important to know not only that a less restrictive treatment facility exists and what it can offer, but also whether or not it has the capacity to accept new treatment cases. Liaison to these agencies might be established through the Guardianship and Advocacy Commission, the Department of Mental Health and Developmental Disabilities, or through the court staff.

IX.6 (**) Consideration should be given to a statutory change to put enforcement power into commitments to a less restrictive

alternative. Judges hesitate to commit respondents to outpatient facilities because there is no legal recourse if respondent fails to participate in the treatment. Mental health professionals argue that the mere fact of a judicial order is frequently enough to encourage treatment participation by many respondents who otherwise would not get the help they need voluntarily. Statutory power to enforce a commitment order, however, would probably go even further in encouraging people to participate in this treatment. For example, if evidence is presented that a less restrictive treatment alternative is failing to meet the person's needs, either because of the person's lack of cooperation or a deficiency in the treatment modality, a hearing could be held to order a new less restrictive alternative or hospitalization for the remainder of the authorized commitment period. The Illinois statute requires a less restrictive alternative to be "adequate," and justification thereby exists for ordering hospitalization if commitment to an LRA fails to produce the desired result.

IX.7 (***) A copy of the 30-day treatment plan, which is filed with the court, should be provided to and reviewed by the respondent's attorney. Chicago hospitals file updated treatment plans approximately 30 days after initiating treatment of a committed patient. Although statute requires that these plans be reviewed by the court, no review of the plans actually is done. Chicago hospitals prepare treatment plans because it is an accepted part of their professional routine and because some must do so to comply with accreditation standards. Because plans are being prepared anyway, the act of filing a treatment plan with the court does not result in better concern for the patient, but just in more paperwork for hospital staff. Mental health professionals and attorneys agree that the requirement to file a 30-day plan is a good one, but only if the plans are reviewed, rather than filed away in drawers. Further, many agree that the appropriate person to review these plans is the respondent's attorney. The major problem with this recommendation is the effect of loading additional responsibilities onto the city's public defenders. In fact, however, only a small fraction of those for whom petitions are filed are committed, and only a fraction of those remain in treatment long enough for a 30-day plan to be prepared. So only a handful of plans would need to be reviewed each month.

IX.8 (**) At recertification commitment hearings, following 60-day or 180-day commitment periods, a review of periodic treatment plans from throughout the treatment period should be required as evidence that treatment has been presented as planned and has been effective. If treatment has not been presented as intended, or if the treatment has shown no positive effect upon respondent, this should be grounds for the patient's discharge or transfer to another facility.

CHAPTER X. POSTHEARING

Description

For those respondents whose cases have been dismissed, the court's involvement ceases. For respondents who are committed to some form of treatment, however, the potential exists for legal problems and court involvement throughout the commitment period. This chapter discusses various issues that may come to the attention of the court following the conclusion of a judicial hearing on involuntary civil commitment. Under the authority of the court order, a treatment institution attempts to exert its influence over the patient's behavior, while the patient may be concerned about the protection of his or her rights, which may conflict with the intentions of the institution. Eventually, the patient or the institution may attempt to initiate the patient's discharge and this may become another point of disagreement and conflict.

A. NOTIFICATION REQUIREMENTS

Notifications appear to be done in Illinois in close conformity with the prescriptions of statute. When a respondent is ordered into treatment, the court's orders are provided in writing to respondent (or the respondent's attorney) and to the director of the facility to which respondent is ordered. This order contains a statement of the findings of fact and conclusions of law from the hearing (3-816(a)).

Another notification requirement arises when the respondent is discharged (3-903(a)). At that time, the facility director must notify the patient of the discharge, the reason for discharge, and patient's right to object to the discharge. Notice of discharge is to be given to the patient at least seven days prior to the discharge whenever possible.

The facility director also must notify the court when a patient is discharged (3-902(c)). The fact of discharge is to be entered into the court record. If the facility director regards the patient as a "continuing threat to the peace and safety of the community," he may notify the state's attorney that patient has been discharged (3-902(d)). In turn, the state's attorney may notify "such peace officers that he deems appropriate" (3-902(d)).

B. RIGHT OF APPEAL

Respondents in Illinois have the right to appeal a commitment order in the same manner as other civil cases are appealed (3-816(b)). The court has a duty to notify each respondent of this right and that a free transcript of the court proceedings and counsel will be provided if respondent is indigent.

In practice, appeals of commitment orders are rare. At best, appeals take from three to four weeks to be heard. By this time, many respondents already have been released from the hospital and have no

further interest in pursuing the legal issues on appeal. Also, after patient's release, the court normally will consider the case to be moot and thus not appealable.

Appeals also are rare because most respondents are concerned primarily with getting out of the hospital rather than with establishing a point of law. For the purpose of seeking release from an institution, other legal actions are much more expedient. A patient can request a discharge hearing, which must be held within a period of five days. A habeas corpus action also can be accomplished more quickly than an appe .. of the original hearing, usually within five days.

C. INSTITUTIONAL ACTIVITIES

For the most part, the court's involvement with the institution ends with the order of commitment. Treatment facilities retain the right to accept or not accept patients into their programs and, once patients are admitted, to select and manage their treatment programs. Private hospitals in the Chicago area generally do not accept commitment cases from the courts, preferring to work with voluntary patients, except in special circumstances. State hospitals exercise their discretion about whether or not to accept a patient during the initial examinations that are used for certification purposes. By allowing a case to progress to a court hearing, the hospital has implicitly agreed to accept the patient and thus plays an integral role in securing the necessary commitment order.

Although the institution is not bound by either statute or court rule to provide specific types of treatment, it is required to plan carefully for treatment and to document treatment activities and patients' progress. As pointed out in a previous chapter, statute requires the hospital to perform a comprehensive physical, social, and psychological examination and investigation of the patient's case within seven days of the time that he or she arrives at the facility, for those cases presented as unable to care for basic physical needs (1-119). The statute requires further that within three days of admission to a facility following a court order, a treatment plan is to be prepared and entered into the patient's record. The plan is to include a needs assessment, recommended services, goals of services, timetable for accomplishing the goals, and designation of responsible professional staff. This plan is to be reviewed and updated as necessary, but at least every 30 days (3-209). Further, it is specified that within 30 days of admission, the facility director must file with the court an updated treatment plan, with an evaluation of the patient's progress and the extent to which he or she is benefiting from treatment (3-814).

Some people who are familiar with the mental health facilities in the Chicago area are of the opinion that therapeutic progress and institutional treatment ought to be carefully monitored for every patient in the state facilities. Most people connected with the mental health system, however, feel that current practices provide sufficient controls and assurances over institutional activities. The first two periods of commitment to a hospital are limited to a maximum period of 60 days

each. A full court hearing is required to extend each of these periods. Thus, with treatment plans and progress reports required on a 30-day basis, the court is assured of having access to treatment plans and progress reports on a monthly basis at least for a five-month period (assuming a continued period of commitment). During this five-month period, which would involve three separate commitment hearings, the patient also has the right to initiate up to three discharge hearings, at which time his or her case would get another thorough review and the hospital records would be scrutinized. This statutory schema provides an extensive system of protections for the patient. No mechanism is provided and no attempt is made to direct specific treatment activities within the institutions; but the review process effectively holds institutions accountable by their results. If patients do not show sufficient improvement, the court may discontinue or alter the involuntary treatment.

Technically, the treatment plan and reporting requirements specified in statute apply equally to community-based, less restrictive treatment alternatives. Chicago judges report little success, however, in receiving progress reports to the court from staff in these facilities. This is another reason why judges hesitate to use less restrictive treatment alternatives.

Note that while no attempt is made to direct therapeutic activities for any particular individual, the Illinois statute does place general restrictions on certain extraordinary forms of treatment. The use of seclusion or restraint, for example, is restricted to therapeutic (not punishment) purposes, and must be performed in accordance with certain safeguards (2-108, 2-109, 2-201). Other procedures, such as electric shock therapy or psychosurgery, may be performed only after the patient has provided an informed consent (2-110). Reportedly, the legal requirements surrounding such treatment modalities are adhered to closely, although some in the mental health community feel that seclusion and restraint are used too frequently in the state hospitals as a means of controlling patient behavior rather than for therapeutic purposes.

Hospitals have the authority to transfer patients if they deem such transfers to be therapeutically beneficial (3-908). After a patient has been in a facility for more than seven days, transfer must be preceded by a 14-day notice of intent given to the patient (3-910). During this 14-day period, the patient may protest the transfer, which will result in an administrative hearing on the question.

The patient's right to object to a transfer has caused some difficulties for hospital staff. Patients are aware, for example, that if they want to fight a transfer decision made during the first seven days of their commitment, they can file a petition for discharge. This will effectively delay their transfer past the seven-day mark and force the hospital to delay the transfer at least two weeks further in order to give the patient the required notice of intent. Additionally, staff at hospitals in the city are annoyed when patients are transferred to Manteno Hospital (which is a long car-ride away) and then request an administrative hearing; the hearing is held at Manteno and requires the

city hospital staff to spend a half day or more traveling to and participating in the administrative hearing.

If a patient has progressed satisfactorily and if it appears that a temporary release would be therapeutically useful for the patient, a facility director can authorize this (3-902(e)). When a patient no longer meets the statutory definition of a person who is subject to involuntary admission, the facility director is to discharge the patient from treatment (3-902(a), 3-902(b)). Whenever possible, a patient is to be given a seven-day prior notice of the intent to discharge and notification that he or she has the right to object to discharge. If a patient objects, he or she will remain in the hospital and an adminstrative hearing will be held on the question.

D. PATIENT RIGHTS AND CONCERNS

The Illinois statute is commendable in its broad protection of patients' rights. The Mental Health Code guarantees their rights to uncensored communications and provides broad protections for their civil and personal rights. Patients are informed of their rights orally by hospital staff and are given written information on these rights as well. A synopsis of patient rights is posted prominently in most hospital wards.

Chicago hospitals are careful to protect the privacy and confidentiality rights of patients also. By statute, patients have the right to designate a number of people to whom notification of their commitment is to be sent (e.g., 3-609). The patient also may direct that no information about him or her is to be disclosed to any other person or agency (2-200(b)). The hospitals in Chicago conscientiously adhere to patients' desires in these respects.

The Illinois statute provides that every patient has the right to be treated in the least restrictive environment, pursuant to an individual services plan (2-102(a)). The plan is to be formulated and reviewed periodically with the participation of the patient and his or her family whenever possible and appropriate. If patients are not satisfied with their treatment plans, they have the statutory right to request a court hearing to review the plan (3-814).

The mental health code also provides for the patient's right to refuse treatment (2-107). Treatment that may be refused includes, but is not limited to, medication. Treatment that is refused by the patient is not to be forced upon him or her unless such treatment is necessary to prevent serious harm to self or others.

Inpatient treatment centers around Chicago reportedly honor the patient's right to refuse treatment. Private institutions, which are populated almost exclusively by voluntary patients, will discharge patients who refuse to accept treatment rather than force the treatment upon them. Public hospitals will honor the patient's right to refuse a particular treatment and will work with the patient in an attempt to institute treatment in other modalities that the patient finds more

acceptable. If a patient in the state hospital obstinately continues to refuse treatment of any variety, the hospital frequently will attempt to transfer the patient elsewhere (such as to Manteno Hospital) or may release the patient rather than continue to hold him or her without providing any form of treatment.

Outpatient treatment facilities depend primarily upon their patients' voluntary desires for treatment. The patient's right to refuse treatment in outpatient facilities is practically absolute; if the patient does not want treatment, he or she simply stops attending the treatment facility.

The issue of a patient's right to refuse treatment after commitment is one of the most difficult issues in mental health law. Contemporary law and practice have firmly fixed the notion that patients may not be held in custody without receiving treatment. Yet, if a patient is allowed to refuse all treatment, the institution is left no options but to release him or her or continue to hold the person without treatment. Moreover, the notion that a person who has been declared mentally ill is ipso facto incapable of making a rational decision about treatment has much commonsense appeal, although it is totally without legal basis in Illinois and many other states. Some statutory schemes have been proposed, in fact, in which incapacity to make treatment decisions would be included in the criterion for commitment, and the involuntary patient thus would retain no right to refuse treatment.

Patients' rights advocates (at one extreme) believe that patients should have the absolute right to refuse treatment. Less extreme advocates point out that patients should be allowed to refuse treatment, but that treatment comes in many forms and some type of treatment probably can be found to which a patient would not object. To some extent, it is argued, the mere environment of a hospital ward is therapeutic and will provide at least minimal treatment to all patients; that is, custodial care <u>is</u> treatment in some cases.

Some doctors believe that the statute is interpreted too strictly in Illinois. For example, it is pointed out that the right to refuse treatment is to be honored unless treatment is "necessary to prevent the recipient from causing serious harm to himself or others" (2-107). Because in most other sections of the statute this type of exception is expressed as "physical harm" (e.g., 2-108, 2-109), this section of the statute (which omits the word "physical") seems to indicate that other types of harm, such as emotional and mental harm, may justify the administration of treatment over the patient's objection. Although contrary to the way this statutory provision reportedly is followed in practice (which is more conservative), this line of reasoning would justify administering medicines to a patient against his or her will if it were deemed seriously harmful to the patient's emotional state not to do so. (It is interesting to note that the text proposed in the 1976 Governor's Report did include the adjective "physical" (p. 27), which does not appear in the current statute. These researchers are unaware of whether the dropping of this word was an oversight or whether the adjective was omitted in line with the reasoning presented by the doctor

who brought this to our attention. At least one judge disagrees with the doctor's interpretation of this part of the statute.)

One doctor who believes that the statute is interpreted too strictly asserts that a distinction should be made between treatment as long-term therapy and treatment designed to address an immediate crisis situation. For example, suppose a patient suddenly experiences a psychotic episode, becomes hyperactive and uncooperative (but not necessarily harmful), and could be settled down by the administration of a single injection. This doctor feels that the treatment should be administered despite the patient's objections in this situation. Again, this opinion is more liberal than the reported practice of honoring the patient's objection.

As a final note on the right to refuse treatment, the issue has been raised of a mental health worker's professional responsibility to coax a patient into accepting treatment. If a depressed patient refuses treatment that would relieve the depression, for example, and if the refusal is seen as a manifestation of the illness, does a professional service provider have a responsibility to try to convince him or her to accept it? The line between friendly persuasion and authoritarian coercion is indeed hard to define. A literal adherence to the statute, honoring without question the patient's right to refuse treatment, is an easy and lawful way to behave; but is it the professionally responsible way to behave?

Returning to the discussion of patients' rights, a patient who is committed for treatment also has a statutory right to request a discharge hearing (3-900). Upon such request, a hearing must be scheduled within five working days, at which time the court is to review whether or not the patient is still subject to involuntary admission, as defined in the statute (3-901). If patient is not released as a result of this hearing, he or she may request other discharge hearings during the remainder of the commitment period, although the court need not grant hearings on these requests.

As mentioned above, patients also have the right to object to transfer or discharge from a treatment facility. Patients must be notified prior to transfer or discharge, and, if they object, they will remain hospitalized. An administrative hearing will be convened to review the transfer or discharge decision; and if the patient is unhappy with the result of this hearing, the issue can be appealed to the facility director, the director of the Department of Mental Health and Developmental Disabilities, and ultimately back to the courts.

E. RECERTIFICATION

The initial period of commitment to a treatment facility is a maximum of 60 days (3-813). A second commitment period of 60 days then can be requested by the hospital. This second commitment requires the same judicial hearing and formal procedures as were followed for the initial commitment hearing. A third and all subsequent periods of

commitment can be authorized for up to 180 days each, each as a result of another full judicial hearing.

A judicial order placing respondent into the care and custody of another person may be for up to 60 days (3-815(a)). Following full judicial hearings, subsequent periods of care and custody can be authorized for a maximum of 180 days each.

Strengths and Weaknesses

A. LEGAL PROTECTIONS

As we have noted before, the Illinois statute is outstanding in its legal protections and is particularly noteworthy in the extensive rights and protections guaranteed to patients. The statute provides broad protections in terms of civil rights, personal rights, and the right to uncensored communications. These rights may be denied only for specific reasons, which are documented carefully in the patient's record.

Hospitals are careful to protect patient rights to privacy and confidentiality. The patient is in control of who shall be notified or not notified of his or her status in the treatment facility.

The statute strongly encourages not only patient awareness of, but participation in, the preparation of a treatment plan. Patient and family are encouraged to work with hospital staff to review the patient's progress and plan future treatment strategies. A court hearing can be requested if the patient does not agree with the plan.

Another legal strength of this statute is the guarantee of patient's right to refuse treatment. Without a separate judicial hearing to establish otherwise, patient is presumed to be competent to make treatment decisions. This right may be curtailed only if necessary to prevent respondent from harming self or others.

Patients are further protected by the requirement that they receive notice of impending transfer or discharge and of their right to object to it. Patients' objections are to be honored pending the outcome of administrative hearings on these questions.

While habeas corpus is a commonly available action for involuntary patients across the country, as well as in Illinois, the Illinois statute is outstanding in its provision for an automatic discharge hearing to be held upon request of the patient. This ensures that any patient may have his or her involuntary status reviewed promptly by the court.

The existence of statutory limitations over more controversial forms of therapy such as seclusion, restraint, and electric shock treatment is another important strength. The law protects the patient's right not to be subjected to these aversive forms of treatment unless certain circumstances and conditions are documented.

Another legal strength lies in the requirements to maintain treatment information and provide it to the court. Treatment plans and reports of patient progress must be prepared for the patient's record as soon as he or she is admitted and at least every 30 days thereafter. The plan prepared after 30 days of treatment must be filed with the court. The court is also to be notified immediately of a patient's discharge. These requirements allow the court to remain knowledgable about any patient's current status. Additionally, a steady flow of information is generated that may be used to support or refute a continuing need for treatment.

One weakness in this system is the length of time it takes to appeal a commitment order. Because three to four weeks are required for an appeal to be processed, few appeals even are attempted. Although respondents have adequate opportunity to seek release from institutions (which is admittedly their primary consideration), they are effectively deprived of the ability to "clear the record" by disputing the initial commitment decision.

Another weakness has been the failure to get effective feedback from outpatient facilities regarding treatment progress. This makes it impossible for judges to monitor the effectiveness of treatment ordered in an outpatient facility and has been a factor in discouraging judges from ordering this type of treatment alternative.

B. PROVISION FOR TREATMENT

The Illinois statute has strict requirements for the preparation of treatment plans. This guarantees that each patient's case will receive continual attention, at least on a monthly basis. In following these requirements, it is less likely that the hospital will neglect any patient, and it forces hospital staff to evaluate their treatment strategies.

Encouraging the patient and family to participate in forming and reviewing treatment plans should have a significant beneficial impact. Patients will be less likely to resist treatment and should be more likely to benefit from it when they have been involved in planning treatment that is both appropriate and desirable.

Finally, for patients who are improving, the statutory right to object to discharge is a strength in this system. A patient who feels that his or her condition has improved but who does not yet feel ready to leave the institution will not be forced to leave without sufficient justification. If the hospital chooses to pursue the discharge against the patient's wishes, it will need to show at an administrative hearing why the patient's discharge is appropriate. It is hoped that this would either demonstrate to the patient that he or she is capable of leaving the institution or convince the institution that the patient's stay ought to be continued.

From a treatment perspective, the patient's right to refuse treatment must be considered a weakness. It is reasonable to assume that

a doctor's decision about required treatment will be better than a lay individual's. Further, when good reason exists to believe that a patient's illness may be impairing the ability to understand what is in his or her own best interest, or when self-destructive tendencies are part of the general problem, this reinforces the belief that a doctor's decisions about treatment may be more valuable than the patient's. Honoring the patient's right to refuse treatment carries the risk of prolonging the patient's state of illness.

C. SOCIAL BENEFITS

An important advantage resulting from the Chicago system is that patients who are committed by the court are virtually always accepted into a mental health facility. Most of the patients who are brought into the judicial hearing process are already in a facility, which is instrumental in establishing the person's need for continuing treatment. This avoids the waste of social resources as well as personal and emotional confusion and inconvenience that could result if a commitment were ordered and no institution would accept the person for treatment.

Another strength, from society's viewpoint, is the statutory provision authorizing a facility director to notify the state's attorney (who may then notify the police) of the release of a person who is considered to be a threat to the community. Circumstances arise in which it is not justified to continue treating a particular individual (e.g., all symptoms of mental illness are in remission), but hospital staff may have strong indications that the person potentially could pose a significant danger to others. Few things seem to upset a community more than learning that a dangerous mental patient has been released into the community with no precautions. Without this statutory provision, hospital personnel might be constrained by the hospital's policies of confidentiality and ethics from alerting legal authorities when a potentially dangerous patient is released.

From a social perspective, some disadvantages also result from the extensive legal protections provided to patients by the Illinois statute. Particularly, the patient's right to be notified of and to object to transfer and discharge can significantly hinder efficient hospital procedures. To comply with the statute, hospitals must wait a period of time before transferring or discharging patients and then can incur considerable delays and costs in going through administrative hearings and subsequent review processes. In a system where patient abuse occurred frequently, these costs could be argued to be well offset by the important benefits of protecting patient rights. Hospital staff in Chicago, on the other hand, feel that their decisions on transfer and discharge are made conscientiously and in the best interests of patients. In their opinion, then, the inconvenience caused by these regulations greatly exceeds the beneficial results they provide for patients. Of course, it also could be argued that it is the existence of these regulations that has encouraged hospital staff to be careful in their transfer and discharge decisions, which justifies maintaining and following them.

Recommendations

X.1 (**) Liaison should be established between the court and any community outpatient facility to which a respondent is committed in order to provide feedback to the court about the patient's treatment progress. It was recommended in a previous chapter that some procedure be initiated to provide more information to the court about community-based, less restrictive treatment alternatives and their current ability to accept new patients. A similar or related mechanism could be used to maintain contact with less restrictive treatment alternatives to which patients are ordered for treatment. It is important for the court to be aware of whether or not a treatment alternative is adequate and effective for the patient and to be kept informed about the patient's cooperation with the treatment facility. It also has been recommended earlier that an enforcement mechanism be established for commitment orders to less restrictive alternatives, providing for action that might be taken if a patient were not cooperative or benefiting from treatment. If an enforcement mechanism were established, this liaison to monitor the patient's progress in treatment would be required to make the enforcement procedure credible.

CHAPTER XI. MISCELLANEOUS ISSUES

Description

This chapter takes up several issues that are not related to any particular part of the civil commitment process and have not been addressed earlier in this report. It also touches on some issues that have been considered in the report already, but that need elaboration or discussion from a broader perspective.

A. COMMITMENT CRITERIA

The Illinois mental health statute, effective as of January 1, 1979, was hailed as a significant improvement over the mental health law that it replaced. Perhaps the most important difference between the old law and the new is the perception that the new statute provides a much more stringent criterion for deciding whether or not a person is mentally ill (or, more precisely, "subject to involuntary admission").

Many people feel that considerable emphasis is given to the aspect of respondent's danger to self or others by the new statute. It is clear from the statute that a person is not to be committed merely because of mental illness. The person must be so impaired in his or her ability to provide for basic physical needs that he or she is unable to guard against serious physical harm; or the person must be "reasonably expected" to inflict serious physical harm upon self or another in the near future (1-119). Of these two aspects of the mental health criterion, the more difficult of interpretation is the one dealing with dangerousness. Whether or not a person presently is unable to provide for basic physical needs can be determined relatively unambiguously. But the dangerousness criterion calls for a prediction, a "reasonable" expectation of what might happen in the future.

Doctors in Chicago generally feel uneasy about being required to predict a patient's future behavior. They point out, and many other people agree, that doctors receive no special training in forecasting future behavior. As a result, doctors have become extremely conservative in their tendency to label a person as appropriate for commitment on this basis. As mentioned in Chapter VI, dangerousness is better assessed on the basis of a report of one or more specific overt and dangerous acts performed by respondent.

People associated with the mental health community generally seem to agree that the new statute in Illinois has made it harder to get people into hospitals as involuntary patients. This cautious approach to treating mental patients seems to have pervaded the system, to the point that it also seems harder for people to enter the system as voluntary patients and that hospitals seem to release patients back to the community, whether voluntary or involuntary, more quickly than in the past. The new statute, of course, coincides with other factors that may have contributed to these effects: the more conservative commitment

philosophy that is prevalent these days, and the diminishing resources that are available for inpatient mental health facilities.

The net effect seems to be more people on the street who have mental health problems. Chicago is similar in this regard to most of the major cities in the country today. A more conservative attitude toward committing people involuntarily, supported by a more stringent mental health code and combined with a lack of resources to support mental patients in hospital settings, leads to an increasingly large population of mentally ill individuals on the streets of the city.

B. THE ROLE OF CMHCs AND LRAs

Nationwide, the need for community-based supporting services for the mentally ill is enormous and continually growing. Community mental health centers and other related facilities serve important roles: (1) as programs of early intervention, to work within the community with mental and emotional problems as they develop in order to prevent or alleviate a more dramatic mental breakdown; (2) as less restrictive treatment alternatives, to provide medication and other therapy without confinement to inpatient wards; and (3) as follow-up programs, to work in a halfway facility with patients who have been released from hospitals, in order to facilitate the transition back into the community.

The network of community mental health facilities in the city of Chicago is widely praised by judges and mental health professionals for the range of services it provides. Many believe that this network dramatically decreases the number of people who otherwise would require inpatient services. It has been suggested, moreover, that the CMHCs can become even more valuable through closer liaison with the courts and with the mental hospitals.

Previous chapters have considered the possibility of commitment to community mental health facilities. For any given case, a judge needs to address two important questions: (1) whether or not the respondent meets the statutory criteria necessary for a commitment; (2) the likelihood that the respondent will cooperate with the outpatient facility so that the court-ordered treatment becomes a reality. Regarding the first issue, it has been argued above that the statute intended for judges to have the authority to order into treatment any person who is sufficiently dangerous or unable to care for basic physical needs, whether or not treatment as an inpatient is required. Second, recommendations have been made earlier in the report that the legal community become more aware of community mental health resources and that closer liaison be established between the mental health and legal communities. Through this liaison, attorneys and judges would be kept informed about a treatment facility's ability to accept new patients, and about the treatment and progress of those patients who were committed into their care.

Community mental health facilities will become even more critical to the court if and as the newly devised "voluntary outpatient treatment" process (see Chapter IX, "Judicial Treatment Options") is used more

frequently. Because the process has no formal force of law, an informal working relationship among all concerned professionals--judge, attorneys, and treatment staff--is essential. Prior to establishing this informal arrangement for a respondent, the judge should be sure that appropriate outpatient facilities exist and are willing to work with the patient. Judges and attorneys depend upon the treatment facility to provide a progress report to the court after a 90-day period, again on an informal agreement that has no force of law. Being relatively new and infrequently used, this process has had promising results for the cases to which it has been applied. Its continued success is ensured, and its ultimate utility can be established, only to the extent that CMHC and court professional staff establish a firm understanding and cooperative work process.

Some of the community mental health facilities also have begun excellent programs of liaison with the public hospitals. These CMHCs are informed by the hospitals of those persons who are denied voluntary admission to the mental health units so that outpatient treatment might be suggested and initiated by the CMHC. Public hospitals and the community facilities also have established mechanisms for referring patients to the outpatient clinics for follow-up support services after their release from the hospital.

The importance of community-based outpatient facilities is of increasing significance. The legal community and the state hospitals have developed working relationships because of their mutual concern for commitment patients. With new statutory emphasis on less restrictive alternatives, a generally more conservative criterion for placing patients into inpatient hospital treatment, and fewer available mental health inpatient facilities, it becomes increasingly important for the community mental health center facilities and staff to become an integral component of the civil commitment system.

C. VOLUNTARY ADMISSIONS

A study of involuntary civil commitment is incomplete without consideration of voluntary admissions for mental health treatment. A patient's legal status as voluntary or involuntary can easily and accurately be determined; but the distinctions between patients who receive treatment voluntarily and involuntarily as a matter of attitude rather than of legal definition are difficult to make. Many patients who are in hospitals on voluntary status reportedly were coerced into making their "voluntary" choice. On the other hand, it is probably more surprising how many patients are processed through an involuntary commitment, displaying little or no aggression or resistance during their hearing process and then cheerfully accepting whatever treatments are administered to them in the hospital.

The reader may wish to refer back to the discussion of voluntary admissions in Chapter VI, which outlined the basic law and practices. This discussion will build upon that discussion and incorporate some additional considerations.

Many advocates for the mentally ill in Chicago feel that the major problem in the city is getting help for those who need it--arranging for the mentally ill to get into the hospitals and keeping them there long enough for treatment to become effective. Staff at some of the community mental health centers are frustrated by the public hospitals' tendency to refuse voluntary admissions for people whom the CMHC staff refer there. Staff from one city clinic estimate that as many as 50 percent of the people whom they feel are appropriate for inpatient treatment and whom they refer to the public hospitals are denied admission.

CMHC staff in some instances have begun extraordinary procedures to try to have their referrals admitted by the hospitals. CMHC doctors admit to "coaching" people on what to tell examiners at the hospitals to convince them that they are mentally ill enough to be admitted for treatment. Sometimes, the doctors at the CMHCs make personal telephone calls to examiners at the hospitals in an attempt to increase the person's likelihood of being accepted into treatment. As a backup measure, CMHC psychiatrists are filling out medical certificates to help family members quickly initiate involuntary proceedings in cases where the persons who need help are denied voluntary admission.

It is generally acknowledged that everyone benefits from a patients' being in the hospital on voluntary rather than involuntary status if admission was, in fact, voluntary. From the patient's point of view, voluntary status generally brings more privileges and a more satisfying experience as a patient. It also enhances the likelihood that therapy will have a successful, positive effect upon the patient. Hospital staff also prefer the voluntary status because of the greater possibility of a successful therapeutic outcome. Additionally, the voluntary status means considerably less paperwork and procedure for the hospital staff. Much time is saved by avoiding hearings and reports to the court.

As the CMHC staff views the situation, hospitals are under increasing pressure to reduce their patient populations because of decreasing resources for mental health. Thus, public hospitals may actively try to discourage admissions. As the court sees it, once an involuntary procedure has been initiated, the hospital stands to benefit from having the admission be voluntary rather than involuntary. The court fears that hospitals may be coercing or inducing people to accept voluntary admissions in something less than a truly voluntary manner. This is responsible for the seemingly paradoxical situation in Chicago where it is reported simultaneously from different sources both that hospitals encourage and that they discourage voluntary admissions.

Another related controversy is over the distinction between informal admissions and voluntary admissions. It was reported in the 1976 Governor's Report that informal admissions tended to be used primarily in private hospitals, whereas the public hospitals tended to admit patients as voluntary rather than informal patients. The Illinois Mental Health Code was written in a manner to encourage the use of informal admissions rather than voluntary admissions in all the city

facilities. To this date, despite the statutory intentions, Chicago judges and some attorneys are concerned that the use of informal and voluntary admission status has not changed with respect to their use by public and private facilities. Judges have begun talking about possible court orders or o her strategies that might be followed to encourage closer compliance with the intent of the Illinois statute.

The differential use by public and private facilities of informal and voluntary admissions, however, is neither hard to understand nor without justification. The major distinction between the informal and voluntary status is the degree of institutional control that can be exercised over a patient who decides to leave. If the patient is on voluntary status, the facility has the right to detain him or her for up to five days, during which time the hospital can petition the court for the patient's continued confinement as an involuntary patient. Private hospitals, of course, rarely have to work with patients who are involuntarily committed. A patient who is in need of treatment and who does not voluntarily accept the prescribed treatment is simply discharged from the hospital. State hospitals, on the other hand, have a responsibility to serve both involuntary and voluntary patients. They are under considerably more pressure to accept all patients who come to them seeking help. Thus, a patient who is in need of help but requests discharge is likely to show up at the hospital again either requesting another voluntary admission or being processed through an involuntary commitment procedure. It is surely more efficient for the public hospital to be able to keep, and to initiate involuntary proceedings for, those patients who enter a hospital voluntarily and are inclined to seek release prematurely. The voluntary status allows the hospital the control to initiate an involuntary proceeding when it is appropriate, while the admission as an informal patient does not. In light of the current situation in which hospitals are seeking ways to decrease their populations, the countervailing concern, that hospitals would unnecessarily prolong a patient's stay with the five-day hold allowed by the voluntary procedure, does not seem to be a serious one.

Another way to understand this situation is to realize that, in practice, informal and voluntary admissions have been used for different types of patients. Informal admissions have been given to people who appear neither to have serious problems nor to present serious threats to themselves or others. People who present more serious symptoms have been admitted as voluntaries, rather than as informals, so the hospital could retain more control of the patient's release if that were necessary. Because of the extremely limited resources available to public hospitals at this time, people who are not seriously ill (i.e., who would have been appropriate for informal admission) simply are not being allowed to enter the hospital. State hospitals are accepting only seriously ill patients at this time: those who traditionally have been accepted as voluntary, rather than informal, patients. Thus, in sum, the difference in use between public and private facilities of the informal and voluntary applications is understandable and probably in the best interests of everyone.

The statute requires that for all patients admitted on voluntary status, the hospital must record the reason that admission was not on an informal status. It is informative that hospital authorities report that such reasons are recorded but are essentially "boilerplate"; i.e., the same basic reason is given for all patients. This indicates that the reason for not using informal admissions is not related to the individual patient but to the commitment system as a whole. By using voluntary rather than informal admissions, hospitals are not denying privileges on a case-by-case basis, but rather are making a policy decision based on the system. Thus, the court would be served less well by reviewing reasons given for the voluntary admission of any single person, and would be served better by reviewing with hospital authorities the broader policy question that is raised.

An important concern in drafting the Illinois statute, as expressed in the 1976 Governor's Report, was to facilitate a person's help for mental problems on a voluntary basis without triggering the involvement of the legal community. If the perceptions expressed by staff in the community mental health centers are correct, i.e., that hospitals are discouraging voluntary admissions, this ought to be more of a concern to the court in Chicago than the differential use of informal and voluntary status admissions. The Governor's Report noted previous complaints about hospitals refusing voluntary admissions to mental health patients. It introduced the administrative appeal process so that people could challenge hospital decisions to refuse voluntary admission. Illinois statute requires that when a person is denied voluntary admission, the person is to be notified of the right to appeal this decision and given information on how to contact the Guardianship and Advocacy Commission.

The process by which to appeal a refusal of voluntary admission as a mental patient probably is ineffective. First, it is questionable whether the right to appeal is effectively made known to people after they are denied admissions. (Community mental health center staff with whom these researchers spoke, having had many of their referrals denied admissions to the hospitals, were unaware of the right to appeal such decisions.) In any event, people who are undergoing enough of a mental health crisis to motivate them to seek admission to a hospital probably are in no condition to understand or act upon their right to an appeal of their denial of admission. Under the best of circumstances, it takes considerable mental alacrity and bravery to challenge an institution as formidable as a public hospital or to initiate contact with a bureaucratic agency like the Guardianship and Advocacy Commission. Indeed, it could be argued that the mere ability successfully to initiate an appeals process and to wait the necessary length of time for it to run its course would be per se evidence that the person did not need mental health treatment and that his or her application to the hospital was rightly denied.

The situation is more complicated with regard to respondents against whom an involuntary commitment is initiated and who then seek voluntary admission. Whether or not the transformation to a voluntary status is in respondent's best interest probably depends upon whether or

not the respondent truly needs mental health treatment. This, of course, cannot be known as legal fact until after a hearing, but some useful information is available as the result of examination by a qualified mental health examiner. If the respondent truly is in need of treatment, the hospital, the courts, and the respondent all benefit from having respondent elect to accept treatment voluntarily. If there is substantial doubt about whether or not mental health treatment is called for, however, respondent's best interest probably would be served by a judicial hearing on the matter.

Judges in Chicago have been concerned that respondents fully understand the consequences of electing voluntary admission. Court rule now requires that counsel meet with respondents and certify to the court that all voluntary applications for admission were truly voluntary and made in full understanding of legal rights and options.

While judges have been concerned about the voluntary election of treatment mostly from a legal perspective, mental health patients' advocates have been concerned about the same issue from the treatment perspective. They point out that while treatment as a voluntary patient is much preferable to treatment as an involuntary patient, a person who has never been a patient has virtually no information upon which to make an intelligent decision about voluntary mental health treatment. Consumers of most services and goods in our society can shop around, see samples, and make trial purchases before they are "committed" to a decision. Patients' advocates would like to see respondents given a tour of mental health facilities, introduced to doctors and other mental health staff, and given a full explanation of potential treatments before they are asked to elect voluntary admission.

Because an election to seek voluntary admission occasionally is disputed by the assistant state's attorney or the judge, some hospitals have begun routinely to complete two mental health examinations and certifications even if the respondent has chosen to seek voluntary admission. Hospital staff do not like this procedure but have chosen to do this so they can effectively advocate for an involuntary commitment if respondent's election of voluntary admission is denied by the court. Hospital staff view this as an inefficient use of their resources. It forces the hospital to perform the second examination within a 24-hour period, which may not be optimally useful either for the hospital or for the patient. It requires that the second examination be done by a psychiatrist, which may not always be the best approach from a treatment perspective. And it requires that the examination begin with the right-to-silence disclosure, which many examiners dislike under any circumstances and which seems especially inappropriate after patient has agreed to seek a voluntary admission.

Patients' advocates do not agree that the practice of having two examinations is necessarily a bad use of resources, however, and recommend that this become a standard requirement in all cases in which respondent elects voluntary admission. It is considered prudent in virtually any other medical procedure for a person to seek "another opinion" before undergoing any serious medical treatment. Similarly, a

respondent may be better advised after talking with two examiners (of which, only the second is required to be a psychiatrist) than after only one examination. The second medical examination may also provide the court with useful information for deciding whether or not to allow the voluntary application. Hospital staff object that this reasoning implies that hospitals are trying to retain patients who do not really need hospitalization. In these days of scarce resources, they counter, this is far from the truth.

D. THE NEED FOR GUARDIANSHIPS

In many interviews with these researchers, people in Chicago expressed a need for more guardianships. Particularly for people who are committed under the criterion of being unable to provide for basic physical needs, commitment to a hospital may not be a sufficient (or totally appropriate) solution. Persons who are unable to care for themselves may be strongly in need of care and treatment. Hospitals are placed in a difficult situation, however, if these people are incapable of voluntarily consenting to hospital treatment or, as a manifestation of their illness, actively protest hospital attempts to provide them with necessary care.

The appointment of guardians in such cases would be beneficial in several ways. A separate court hearing could establish the respondent's incapacity for making treatment decisions and then assign the responsibility for making these treatment decisions to a guardian. The guardian then would be able to work actively with hospital staff in designing a program of treatment in respondent's best interests. The guardian also could take responsibility for planning a transition from the hospital back into the community. He or she could investigate halfway houses or community clinics that could provide maintenance therapy to obviate the need for hospitalization. The guardian could be responsible for monitoring progress during the hospital stay as well as making periodic checks on the respondent after respondent's return to the community.

The guardianship concept is theoretically sound but difficult to implement. The legal mechanics are reportedly exceedingly difficult and time consuming. Hospital staff report that efforts to establish a guardianship have taken between three and six months and consumed nearly one staff person's full-time effort during that period.

Aside from the legal obstacles, perhaps the greatest problem is identifying people to serve in the role of guardian. The ideal guardian is a friend, in the fullest sense of the word. Because a guardian may be instrumental in initiating or continuing a period of involuntary commitment, the potential for a conflict of interest is significant. A close relative, for example, especially if he or she is potentially an heir or beneficiary, conceivably might have other motives than the best interests of the respondent. A guardian who is a member of the state hospital staff similarly could be suspected of harboring interests other than those of the respondent. Mental health and social services staff, not connected with the state hospital system, might function excellently

as legal guardians if this were to be built into their job responsibilities. Attorneys also would be uniquely qualified to serve as guardians to people with whom they have had no previous personal or professional relationships.

Some expense undoubtedly would be connected with establishing guardianships, but the expense may be easily justified. In many cases, it may be more cost-effective for the state to pay social-work staff to serve as guardians than to bear the repeated court and hospital costs associated with recurring commitments of these persons. The nonmonetary benefits of providing people with stable lives and minimizing their annoying effects on society also should be considered.

E. THE ROLE OF THE GUARDIANSHIP AND ADVOCACY COMMISSION

The Guardianship and Advocacy Commission was created by the Guardianship Advocacy Act, effective as of January, 1979. The Guardianship and Advocacy Commission was to contain a Legal Advocacy Service having two basic functions: (1) to make counsel available to persons in mental health judicial proceedings, including those relating to admission, civil commitment, competency, and discharge; and (2) to make counsel available to enforce any mental-health-related rights or duties derived from local, state, or federal laws. The Guardianship and Advocacy Act also established within the Commission an Office of State Guardian, which was authorized to act as a guardian ad litem for any person in the state for whom a private guardian was not available.

The Guardianship and Advocacy Commission is reportedly not very active in the City of Chicago. Their staff and their work are highly complimented but generally considered to be too few and too little. Like everything else connected with mental health treatment, the Guardianship and Advocacy Commission apparently suffers from a lack of resources.

The Illinois statute (3-805) intended that Guardianship and Advocacy Commission attorneys play a major role in involuntary commitment hearings. If counsel is to be appointed, the statute directs the court to appoint an attorney employed by or under contract with the Guardianship and Advocacy Commission. Only if an attorney from the Commission is not available is the court to appoint the public defender. Yet, the vast majority of respondents are rep esented by the public defender in Chicago and only very few are represented by attorneys from the Guardianship and Advocacy Commission. The quality of legal representation provided by the public defenders is quite good and suffers only from the extremely heavy caseload they are forced to bear; thus, there is no intent to disparage the services currently provided by the public defenders. But it is of interest to note in the commentary of the 1976 Governor's Report: "It is anticipated that the Legal Advocacy Service will supplant and take over many of the responsibilities in commitment hearings presently delegated to the county public defenders" (p.5).

The Guardianship and Advocacy Commission is a highly useful body that potentially could serve many more functions within the mental health

system. In concept, it is highly similar to the Mental Health Information Service, which functions as an arm of the courts in the State of New York. The Mental Health Information Service employs a cadre of attorneys and social workers who work out of offices within the state hospitals, making their access to patients quick and easy and their involvement in mental health law ubiquitous.

During interviews with people in Chicago, and based upon observations in other cities, many suggestions have been offered for ways to improve and expand the role of the Guardianship and Advocacy Commission. Earlier recommendations suggest activities in which the Commission could become involved. These recommendations could be implemented more effectively, perhaps, if they were assigned to a central agency such as the Commission. Making the admittedly enormous assumption that the Commission's staff and monetary resources could be expanded sufficiently to place social workers and attorneys on permanent assignments within the public hospitals, Commission staff could serve in the following functions.

1. Liaison to Community Treatment Facilities. These staff could be responsible for being familiar with outpatient facilities available in the Chicago community. They would know the types of services that the facilities provided and the types of patients who would be appropriate for them. As patients came into the hospital, these staff people could carefully consider the possibility of less restrictive community placements and could provide this information to the court. They could be responsible for contacting each facility to determine their willingness and ability to accept a respondent as a new patient. This liaison activity also would be important, of course, for hospitalized patients as they become ready to leave the hospital and re-enter the community. Commission staff could arrange for transitional services or check to ensure that the hospital staff is doing a sufficient job in this regard. It should be noted that given the high cost of hospital care, a conscientious job done by a Commission social worker that would result in a more efficient use of community resources and a decreased need for hospitalization would make the position highly cost-effective, as well as provide a service that appears to be strongly needed.

2. Patient Advocates. The need for effective patient advocacy within the hospitals has been mentioned previously. When patients first come to the hospital, there is a need for someone to read them their legal rights and protections and explain carefully what these mean. These staff would be available on a regular basis and easily accessible to patients who felt that they had been abused or mistreated in any way, or who wanted information about their legal rights or the procedures available to them to seek their release. Commission staff members in the hospitals could be assigned the responsibility for monitoring the 30-day treatment plans

that currently are filed with the court but do not receive the review that is contemplated by the statute. Through spot checks and casual observation, they also could ensure that the hospital is in compliance with statutory requirements relating to the use of special therapeutic procedures such as seclusion, restraints, electroshock therapy, and so on. They would be sensitive to staff compliance with patient refusal to accept treatment, and could be available to help hospital staff decide whether a dangerous situation warranted an exception to the patient's right to refuse. Finally, if a person applied for voluntary admission for mental health treatment and was refused, the Commission staff member at the hospital could be available immediately to talk with the person, initiate an appeal of the admission decision if needed, or refer the person to an alternative community resource.

3. Guardians. Commission staff within the hospitals could determine appropriate cases for the appointment of guardians and begin the legal work necessary for such actions. They could check with the respondent's family and friends to determine whether a suitable private guardian is available. Perhaps on a temporary basis, Commission staff could be appointed as guardians themselves.

F. RESPONDENT SELF-INCRIMINATION

In Chicago, respondents are subjected to a seemingly contradictory system of rules and procedures regarding the provision of information that might be harmful to their cases. The Illinois statute is one of few in the country that grants the respondent the right to remain silent during a psychiatric examination. Psychiatric examiners are required to explain to respondent the purpose of the examination, to warn him or her that the information given to the examiner may be used in court, and to indicate clearly that respondent has the right to remain silent during the examination. If this is not done, the examiner is specifically barred from testifying in court. The 1976 Governor's Report obviously intended this provision of the statute as a privilege against self-incrimination.

Once the respondent reaches a Chicago courtroom, however, the privilege against self-incrimination seems to evaporate. Public defenders report that the state occasionally will call a respondent to the witness stand in the obvious hope that respondent will "hang himself." Having failed to demonstrate convincingly that respondent meets the statutory criteria for commitment, the state may hope to impress upon the judge how "sick" the respondent really is by asking respondent to take the stand and discuss the delusions or hallucinations that form the basis of the mental illness diagnosis.

Supposing that a respondent were savvy enough not to speak with an examiner, in order to avoid self-incrimination, this privilege could easily be disintegrated in the courtroom. The assistant state's

attorney, with a psychiatrist by his side, could call respondent to the witness stand and ask him or her a series of questions that, in essence, could serve as the basis for a psychiatric examination. The psychiatrist then could be called to the stand to testify as to his or her professional opinion about the respondent's condition.

If courtroom practice and Illinois statute are to remain in agreement, a change in one or the other seems to be called for. Public defenders feel strongly that their ability to represent their client and provide effective legal counsel is seriously undermined by the state's attorney's authority to order respondent to take the witness stand at a hearing. In some other states respondents are notified in court that they may not be forced to testify if they do not wish to do so. A procedure of this sort would be congruent with the spirit of the Illinois statute as well. Unfortunately, present practice is mandated by the Illinois Civil Practice Act, which specifically denies to the defendant in a civil case the right to refuse to testify against his or her own best interests.

G. CONFIDENTIALITY OF RECORDS

Another area of apparent contradiction in policy concerns the confidentiality of mental health records. Chicago hospitals are very sensitive to the provisions of the Mental Health and Developmental Disabilities Confidentiality Act as well as to the professional statements of ethics and confidentiality that guide their various staff. The hospitals do a conscientious job of protecting patients' privacy and confidentiality as well as possible. The Mental Health Code also authorizes the respondent to direct, if he or she wishes, that "no information about the recipient be disclosed to any person or agency" (2-200(b)).

Occasionally, the zeal with which the hospitals protect patient confidence can be annoying or cause real problems. Relatives who telephone the hospital usually will not even be told whether or not respondent is a patient there, much less be given any information about him or her. Even the Chicago police and other investigative agencies, in their work on problems such as missing person cases, will not be given information about patients in the hospital.

In stark contrast, the court documents and proceedings are open to the public. The public is allowed to attend all hearings unless good cause is shown to have them excluded, and public access to court files is essentially unrestricted.

An important contradiction in policy occurs when hospital records become part of the court record. Hospital information, which otherwise would be maintained in strict confidence, is presented in testimony in open court. Medical certifications become part of the respondent's court record. A treatment plan is filed with the court within 30 days of patients' admission containing a full description of the patient's condition, treatment that is planned, and an assessment of progress to date. All this information then becomes part of the public record.

It is ironic that this problem seems to be at the same time extremely important in concept and extremely unimportant in practice. It is highly important to the hospitals that their work remain confidential; it is equally important to the courts that their work remain public. Yet, in all the interviews conducted by these researchers in Chicago, these conflicting values and practices were never identified as a serious source of difficulty and nobody expressed concern that confidential hospital records were easily available through public court files.

The intention here is merely to identify this apparent incongruity as a potential problem. Heeding the wise maxim that goes, "If it isn't broken, don't fix it," and seeing no simple solution to this situation, these researchers will offer no recommendations for change in this regard. One recommendation will be offered in the final portion of this chapter, however, regarding easier access to information from the hospital in cases where this might be in the patient's best interest.

H. EDUCATION

The civil commitment of the mentally ill necessarily integrates the knowledge and skills of professionals in two areas: law and mental health. Most of the workers in this system, however, have had formal training only in one or the other of these disciplines. Mostly through on-the-job training and occasional workshops and seminars, people develop a working, albeit limited, knowledge of the relevant theory and practice of the "other" discipline.

Professionals from both the legal and mental health communities express their impressions that the "other" group is in need of further education. Judges and attorneys would like doctors and psychologists to be more familiar with civil commitment laws and legal procedures. Mental health professionals, on the other hand, feel that judges and attorneys do not understand the nature of mental health hospitals, of community-based treatment facilities, and mental health treatment.

Some special training has been offered in Chicago and has been greatly appreciated by those who received it. Medical schools apparently give some limited coursework to psychiatrists on legal aspects of mental health. Psychiatrists in the CMHCs also have benefited from special training sessions on the topic of mental health examinations and certifications.

Two distinct types of problems must be confronted. First, training is needed for orientation. Judges and attorneys who have never been involved with civil commitment cases frequently are unfamiliar with the statute, let alone with psychiatric jargon. Mental health professionals frequently are not only unfamiliar with, but offended by, the adversary nature of the judicial system. A standard packet of orientation materials that would provide a theoretical and practical introduction to the mental health area and an explanation of the Chicago civil commitment system would be of benefit to and greatly appreciated by inexperienced professionals.

The second major component of training is continuing education. Civil commitment practices in this country have undergone enormous changes in the last decade. Laws evolve constantly, in reaction to a changing social environment and generational cycles of standards and morality. Medical and psychological research bring constant change to the frontiers of knowledge of how to define and treat the mentally ill. Economic and social developments dramatically affect the nature and number of community services for the mentally ill. People who work within the mental health system must keep abreast of these developments and interact with other people who work in the system, in an away-from-the-work environment in which ideas and points of view can be exchanged freely.

Recommendations

XI.1 (***) All community mental health centers that have not already done so should establish effective ongoing liaison with state hospitals to facilitate referral of all cases in their catchment area that are denied voluntary admission by the hospital and all patients who are discharged from the hospital and would benefit from transitional support services. Many community mental health centers and hospitals already have established such liaison. Cooperation between the staffs of these institutions promotes efficient use of mental health services and enhances the treatment of individuals in the community. Where this liaison has not been established or is not working effectively, however, gaps or duplications of services are likely to exist and problems that patients have in the transition from community to hospital and back again will be exacerbated.

XI.2 (***) Some means should be established to expedite significantly the appeal process after the rejection of a patient's application for voluntary admission to a hospital for mental health services. It is widely agreed that mental health treatment is more effective in the earlier stages of a problem and that voluntary patients respond better to therapy than involuntary patients. Further, a tremendous amount of anxiety must accompany every person and his or her family when they present themselves at a hospital and request admission for mental treatment. For these reasons, great care should be taken that voluntary admission is not improvidently refused to those who request it. On the other hand, mental health facilities are crowded, chronically underfunded, and commonly under pressures to reduce patient populations. Patients who do not truly need this service, or who use it only as a free bed for the winter months, should be discouraged from seeking such treatment. When CMHC psychiatrists report, however, that they are referring people to the state hospitals, that the people are seriously in need of help, and that the hospitals are turning them away, this is cause for concern. Perhaps it needs to be stressed that people who present themselves for voluntary

admission do not need to meet the rigid criteria required for an involuntary commitment. That is, a valid applicant for voluntary admission may only meet half the statutory criteria for commitment (i.e., may be mentally ill) and the hospital treatment may often prevent the person from becoming dangerous or unable to care for basic physical needs to the degree that involuntary commitment ever would be required or justified.

We have observed that the current review procedure available to people who are denied voluntary admission apparently is not a practical one. It needs to be replaced or supplemented with some other procedure so that people can more easily and effectively appeal the denial of admission. One possibility might be the identification of an individual who is on call at all times in the hospital and able to act as a patient advocate. If a person is denied voluntary admission to the mental health facility, this patient advocate could meet with the person immediately to review his or her case and would have the authority to compel immediately a second, independent examination. If the second examiner confirmed the first examiner's opinion that voluntary admission would be inappropriate, or if the patient advocate believed that the voluntary application was inappropriate, the advocate could direct the person to alternative treatment facilities available in the community.

The thrust of this recommendation is of major importance. Many people in the Chicago community have expressed the opinion that it is currently extremely difficult to get help for the mentally ill until a problem is so severe that the patient has deteriorated badly and his or her behavior is quite bizarre. Arguably, it is appropriate that such extreme behavior should be required before authorizing an involuntary commitment. There is little justification, however, for a system in which people must show dramatic symptoms of mental illness before treatment can be provided to them on a voluntary basis.

XI.3 (**) Administrators of the city mental health clinics and state hospitals should develop and implement a more cooperative procedure for referring patients from the city clinics to the state hospitals, in order to effect a significantly lower rate of admissions refusals. The recommendation immediately above explains the importance of making voluntary admission available to those people who truly need it. An expedited appeals process would be an important procedure to ensure that this occurs. Additionally, however, people who come to the state hospitals and seek voluntary admission on referral from a psychiatrist at a mental health center ought to be given special consideration at the state hospital. People who come to the state hospital off the streets, without such guidance, may more frequently be mistaken in their belief that hospitalization is needed. Those who are referred by the city

mental health clinics, however, have been examined by competent psychiatrists and have had a professional diagnosis of their condition and needs. These people ought not to be turned away summarily. At the very least, hospital examiners with any doubts about the patient's needs ought to telephone the CMHC psychiatrist immediately to discuss the case. If this is impossible, perhaps the patient could be held temporarily until the CMHC psychiatrist could be contacted, another, more extensive examination might be made, or very-short-term therapy might be administered to help the patient overcome the immediate crisis situation.

XI.4. (**) The court should meet with state hospital administrators to review their reasons for their use of voluntary rather than informal admissions, and the court should not interfere with this practice unless it clearly can be shown not to be in the best interests of society and respondents. Despite the intentions of those who drafted the Illinois statute, good reasons may exist for the use of voluntary admissions (rather than informal admissions) in the public hospitals in Chicago. These researchers have the impression that the legal community and the mental health community differ in their opinions about why this practice exists and whether or not it ought to continue. We recommend that the court meet with hospital administrators and discuss this carefully before the court exercises its authority in an attempt to alter this practice.

XI.5. (*) After an involuntary commitment has been initiated, a respondent who is considering voluntary admission should be given more complete information about what he or she is "buying"; counsel should certify for the court that such information has been given to the patient before the court accepts the voluntary application. Presently, the court asks counsel to certify that the patient understands his or her actions in seeking voluntary admission and that voluntary admission has not be coerced in any way. In addition, a greater attempt should be made to explain to respondents, especially those who have never been patients in a mental institution, exactly what voluntary treatment entails. At a minimum, this should include the patients' being shown the ward in which he or she will be held, meeting some of the hospital staff, and being given an explanation of treatments (and possible side effects) that he or she might expect to receive.

XI.6. (**) Once an involuntary commitment proceeding has been initiated and the respondent has requested voluntary admission, if the court has any question about whether voluntary admission is appropriate or needed, it should require the filing of a second certificate of examination. If two certificates already have been filed, the court should exercise its authority to require another, independent examination. This recommendation offers several benefits. First, for the patient, an additional opinion will be given to confirm for the patient that mental

health treatment is needed and appropriate. If the additional examiner does not agree that mental health treatment is needed, the respondent would be released as required by law. Having thus eliminated any possibility of involuntary commitment, the patient may well decide not to make voluntary application. If the patient still wishes to be admitted, however, his or her application unquestionably would be voluntary. Second, in any event, the judge will be better informed about the patient's condition and better able to decide whether to allow or disallow the voluntary application. Third, for the state, all necessary examinations and certificates will be available promptly if voluntary admission is denied and involuntary proceedings are continued.

For reasons discussed more fully in the earlier part of this chapter, a second certificate should not be required in every case in which voluntary application is made, although some hospitals may choose to impose this requirement upon themselves. If a voluntary application seems likely to be accepted in court, great cost and little benefit come from a second examination and certificate. In those cases in which questions may arise, however, second and even third opinions about respondent's condition should be sought in deciding whether or not to allow a voluntary admission.

XI.7. (*) Procedures should be explored to facilitate the legal process of appointing guardians for respondents who are not able to provide for their basic physical needs. The potential usefuless of guardians in mental health cases is widely acknowledged. The process of appointing a guardian, however, involves a long time period and a heavy investment of staff effort. This complex and burdensome legal process discourages the appointment of guardians in cases where they might be useful. A process to simplify and expedite guardianship appointments would be beneficial for many patients. As an example, perhaps an abbreviated procedure could be used to establish a temporary guardian, while the more thorough procedures to establish a permanent guardian were completed. Another suggestion is that guardianship cases be assigned to the jurisdiction of the commitment courts, instead of or in addition to the probate courts, in which jurisdiction now resides. Within the commitment courts, cases might come to quicker and easier resolution, and the guardianship and commitment aspects of the case could be considered in concert.

XI.8 (*) The court and community care-providers should explore possible sources of people who could be appointed legal guardians to respondents who are not able to provide for their basic physical needs. Although the usefulness of guardians in mental health cases may be considerable, a major difficulty in establishing such relationships is the identification of people who are suitable for appointment as legal guardians. In a city the size of Chicago, however, some solution to this problem

probably can be found through a concerted effort of professionals who are involved with such cases. For example, community and civic service groups may have individuals who have the time and disposition that would make them appropriate as guardians for the mentally ill, if they could be approached and educated about this need. Attorneys in the community might be persuaded to become guardians for one or more patients as a type of pro bono legal service in fulfillment of their professional responsibilities. Staff of mental health and social welfare institutions could be another source of guardians.

XI.9 (***) Careful consideration should be given to the feasibility of extending staff and activities of the Guardianship and Advocacy Commission in the Chicago area by having Commission staff act as (1) liaison to community outpatient facilities, (2) patient advocates, and (3) guardians ad litem. Those who drafted the Illinois statute seemed to envision a greater role for the Guardianship and Advocacy Commission than it currently plays in the Chicago area. While resources for mental health services are unfortunately limited these days, the need for an advocacy commission for mental health patients was adequately documented in the 1976 Governor's Report and has been discussed in some detail in this report as well. The Guardianship and Advocacy Commission has achieved an excellent reputation for the limited amount of work in which they have been involved. The expansion of services provided by this agency would be a highly cost-effective manner to provide needed services that are not now available and to supplement services that currently are inadequate. Recommendations for specific staff activities were made earlier in this chapter.

XI.10 (**) The mental health code should be amended to specify that a respondent has both the right to testify and the right to refuse to testify at his or her hearing. Alternatively, the Illinois Civil Practice Act should be amended to specify that the respondent in a civil commitment shall not be compelled to testify at his or her hearing. As explained in more detail in the text above, the Illinois mental health code explicitly provides to respondent the right against self-incrimination during examination by a psychiatrist who will testify at his or her hearing. The spirit of the statute, granting the privilege against self-incrimination, should not be negated by forcing a respondent to testify against him or herself at a hearing. The Illinois Civil Practice Act, however, gives the state's attorney the authority to do this. Without some form of statutory change, respondents will not have the right that the mental health code intended.

It should be acknowledged, nevertheless, that some judges firmly believe that it is in respondent's best interest to allow any judicial procedure to help reveal the "truth" about respondent's condition and his or her need for mental health

treatment. From this point of view, respondent is not "incriminating" him or herself by testimony that reveals to the judge a need for hospitalization. It is in deference to this countervailing opinion that this recommendation is given two asterisks rather than three.

XI.11 (***) Upon request for information about a patient, hospital staff should not automatically refuse to provide the information; rather, staff should immediately check with the patient and inquire whether or not the patient wishes to authorize release of the requested information. Chicago hospitals apparently do an excellent job of protecting the confidentiality of patient information. When concerned relatives (or police in a missing person investigation) are unable to get information about a mentally ill relative, however, it might be concluded that the hospitals are doing their job too well. Reportedly, at least some of the hospitals in Chicago routinely deny any information to callers unless specific authorization for the release of such information has been made in advance by the patient. A better procedure might be to record every request for information with a promise to call back. Then, after checking with the patient (if there is such a patient in the hospital), staff can return the call and provide whatever information has been authorized for release or a general statement that, "this hospital does not have any authorized information about a patient by that name." This procedure would protect the confidence of patients whenever that was desired but also would provide information for persons authorized by the patient to receive it.

XI.12 (**) Court and state hospital officials should arrange for the preparation of a set of standard orientation materials to be used by legal and mental health professionals who become involved with civil commitment in Chicago. Too many legal and mental health professionals become involved in civil commitment cases without proper education or preparation. Although everyone learns, to a more or less adequate degree, by trial and error, many professionals regret their inadequate formal training. A set of standard orientation materials would help ensure the consistent application of principles to these cases and would facilitate the entry of new professional people into the system.

XI.13 (**) Court and mental health professionals should arrange for periodic continuing education seminars in the Chicago area to keep people who work in this system up to date on relevant developments in law, medicine, and society. The mental health law area is one that continues to see important changes. The conscientious application of state-of-the-art thinking with regard to legal, psychiatric, and social concepts in mental health requires continual education. A program of periodic continuing education seminars, held on a regular basis two or three times per year, would help maintain a high level of

expertise among professionals in the Chicago area. It would enable a stimulating interchange of ideas and opinion that would probably have a beneficial impact on service provision to the mentally ill.

Appendix A

Statutory Analysis

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Part 2. Illinois Statutory Analysis

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PART 2. ILLINOIS STATUTORY ANALYSIS

ILLINOIS STATUTORY ANALYSIS

PART I: PREHEARING MATTERS

SECTION 1 Initiating a Commitment

i. Means of Initiation

Emergency Admission:

1. Petition is presented to or prepared by a facility director. 3-601.
2. Peace officer takes into custody and completes petition. 3-606.
3. Court orders detention and examination. 3-607.

Court Order Admission:

Petition is filed with court. 3-701.

ii. Who May Initiate?

Emergency

Any person 18 years of age or older. 3-601(a). Peace officer (3-606) or court (3-607) based on observation.

Court Order

Any person 18 years of age or older. 3-701(a).

iii. Supporting Allegations, Petitions, and Attachments

Emergency and Court Order

Petition must include:

1) detailed statement of reason, including description of acts and threats and their time and place of occurrence;

2) name and address of relative or friend of respondent, or statement that diligent inquiry was made to learn this information;

3) statement of petitioner's relationship to respondent and disclosure of legal or financial interests in matter or involvement in litigation with respondent;

4) information about witnesses by which assertions may be proved. 3-601.

Petition must be accompanied by examiner's certificate indicating personal examination no more than 72 hours prior to admission. Certificate also must contain examiner's clinical observations and other relevant factual information. Must indicate whether respondent was advised of his or her rights. 3-602.

Without examiner's certificate, person can be detained up to 24 hours until certificate is furnished. 3-604. But, petition then must also have statement that no examiner could be found who has examined or could examine respondent. 3-603.

State's Attorney shall ensure that petitions, reports, and orders are properly prepared. 3-101.

Every petition, certificate, and proof of service shall be executed under penalty of perjury as though under oath or affirmation. 3-203.

Within 24 hours following admission, two copies of petition, first certificate, and proof of service of petition and statement of rights to respondent must be filed with court. Second certificate must be filed promptly with the court. 3-611.

Court Order

Certificate is also required from examiner at mental health facility prior to hearing. If first certificate was not filed, mental health facility is required to have two independent examinations and certificates, one of which must be done by a psychiatrist. If first certificate was not by psychiatrist, mental health examiner must be a psychiatrist. 3-703.

Emergency

Within 24 hours of admission, respondent must be examined by a psychiatrist (who did not do first examination) who then prepares a second certificate. 3-610.

iv. Screening Mechanisms

Emergency and Court Order

The court may inquire whether reasonable grounds exist to support the allegations in the petition. If an emergency exists, this may be done without notice to respondent. 3-701b. Court finds documents in order. 3-702.

v. Criteria for Initiation

Emergency - Assertion by petitioner, or reasonable grounds to believe (based on personal observation) by peace officer or judge, that respondent is subject to involuntary admission and in need of immediate hospitalization to protect such person or others from physical harm. 3-601, 3-606, 3-607.

Court Order - Assertion by petitioner that respondent is subject to involuntary admission. 3-701. Court finds documents in order. 3-702.

SECTION 2 Alternatives to and Diversions from Prehearing Detention

Person under involuntary petition may remain at home pending examination and pending hearing. 3-704, 3-706.

SECTION 3 Authorizing Detention

i. Criteria for Detention and Required Standard of Proof

Emergency and Court Order - same as Section 1v. Criteria for Initiation. Note: standard of proof for Court Order is not specifically mentioned.

ii. Authority to Order Detention

Emergency - Facility director. 3-601, 3-603. Peace officer. 3-606. Court. 3-607.

Court Order - Court. 3-704.

SECTION 4 Taking Respondent into Custody

i. Procedures for Taking Respondent into Custody

Emergency - On receipt of petition and certificate, peace officer takes respondent into custody. 3-605. Peace officer takes into custody as a result of personal observation. 3-606.

Court Order - Respondent may be accompanied to examination by relatives, friends or attorney. 3-704. See also, Emergency, above.

ii. Notifying Respondent of His or Her Rights

Any required statement or explanation for a "patient" who does not understand English shall be furnished in a language he or she understands (but this does not apply to petitions and court orders). 3-204.

Within 12 hours after admission to a facility, respondent is to receive a copy of petition and a clear and concise statement of his or her legal status and right to counsel and to a court hearing. After hospitalization, any changes in respondent's legal status must be explained to him or her. 3-205, 3-609.

Upon completion of medical certificate, respondent shall be informed of the right to refuse medication. 3-608.

The respondent shall be asked if he or she wishes to have copies of the petition and statement of legal status sent to any other (than attorney and guardian) persons, and at least 2 such persons indicated by respondent shall be sent copies. 3-609, 3-704b.

At least 36 hours before time of examination fixed by the court, the respondent, attorney, and guardian are to receive a statement of rights. 3-705.

iii. Payment

Not specifically mentioned.

SECTION 5 Prehearing Detention

i. Place of Detention

Emergency

A mental health facility. 3-605.

Court Order

Whenever possible the examination shall be conducted at a local mental health facility. 3-704.

ii. Maximum Period of Pre-hearing Detention

Emergency

No person detained for examination may be held more than 24 hours unless a medical certificate is furnished. 3-604. Within 24 hours after admission, a facility staff psychiatrist must examine and file a certificate; if not done, respondent is released. 3-610. Within 24 hours of admission, petition and certificate must be filed with the court. Second certificate must be filed promptly. Hearing to be set within 5 days after receipt of petition. 3-611.

Court Order

No person may be detained for examination for more than 24 hours. 3-704. Hearing shall be held within 5 days after receiving second certificate or admission, whichever is earlier. 3-706.

iii. Authority to Transfer Custody

Not specifically mentioned.

iv. Transfer from Criminal Custody

Not specifically mentioned.

v. Provisions for Payment

Not specifically mentioned.

SECTION 6 Notice of Detention

i. To Whom is Notice Given?

Both - Respondent's attorney and guardian. 3-609, 3-705.

Emergency - At least 2 persons designated by respondent. 3-609.

ii. By Whom?

Facility director. 3-609, 3-205. Court. 3-705.

iii. Timing

Emergency

Not later than 24 hours after admission. 3-609.

Court Order

At least 36 hours before the time of examination fixed by the court. 3-705.

SECTION 7 Provision of Counsel

i. Right to Counsel

Every respondent alleged to be subject to involuntary admission shall be represented by counsel. A hearing shall not proceed without counsel unless respondent, after conferring with counsel, requests to represent himself and court approves. 3-805.

ii. Provision of Counsel for Indigents

Court shall appoint counsel for indigents. 3-805. Court shall appoint an attorney employed by or under contract with the Guardianship and Advocacy Commission if one is available. 3-805(1). If not available, court shall appoint public defender; if public defender not available, court shall appoint private attorney. 3-805(2).

iii. Method and Timing of Appointment of Counsel

Prior to a hearing. 3-805. For method, see ii. above.

iv. Counsel's Responsibilities and Rights to Access

Counsel shall be allowed time for adequate preparation and shall not be prevented from conferring with the respondent at reasonable times nor from making an investigation of the matters in issue and preventing such relevant evidence as he believes is necessary. 3-805.

The Guardianship and Advocacy Commission attorneys shall:

1. Have ready access to view and copy all mental health records pertaining to clients as provided in the Mental Health and Developmental Disabilities Confidentiality Act, and

2. Have the opportunity to consult with his clients whenever necessary for the performance of his duties. Service providers shall provide adequate space and privacy for consultation. No attorney shall have the right to visit eligible persons or look at their records for the purpose of soliciting cases for representation. Guardianship and Advocacy Act, 712.

v. Provision for Payment

Private attorney files with court verified statement of legal services. Court determines reasonable fee. If respondent is unable to pay, court enters an order for county to pay entire fee, or such amount as respondent is unable to pay. 3-805(3).

SECTION 8 Prehearing Examination

i. Timing

Emergency

First one up to 72 hours prior to petition or within 24 hours of detention. 3-604. Second within 24 hours after admission. 3-610.

Involuntary

Within 24 hours of detention for examination. 3-704.

Both

When any person is presented for admission to a mental health facility, within 7 days thereafter the facility shall provide or arrange for a comprehensive physical and mental examination and social investigation of that person. This examination shall be used to determine whether some program other than hospitalization will meet the needs of such person with preference being given to care or treatment in his own community. 1-119(2) (Applies only to those who are "presented for admission" as being unable to provide for basic physical needs.)

ii. Examiner Qualifications

Qualified examiner is a person

1) Registered or certified by State as
   a) certified social worker with M.S.W.; or
   b) registered nurse with M.S. in psychiatric nursing; and

2) Who has 3 years of training and experience in evaluation and treatment of mental illness subsequent to that degree. 1-122.

Psychiatrist is a physician with 3 or more years of training or experience in diagnosis and treatment of mental illness. 1-121.

Clinical psychologist is a psychologist registered with State who has

a) doctoral degree and 2 years of experience (one postdoctoral and one in organized health service program); or
b) graduate degree in psychology and at least 6 years of experience as a psychologist with 2 years experience in health services. 1-103.

Physician is a person licensed by State to practice medicine. 1-120.

All can examine respondent for first certificate (out of two required). But second certificate must be filed by a psychiatrist (see Part I, Sections 1 iii.).

After admission to a facility, examination must be done by a psychiatrist. 3-610.

iii. Right to Remain Silent

Respondent does not have to talk to examiner, but any statements he or she makes may be disclosed at the hearing. If the person is not informed of this, examiner will not be permitted to testify at hearing. 3-208.

iv. Right to Independent Examination and Social Investigation

Respondent is entitled to independent examination. If unable to afford it, he or she may request a court order for examination by an impartial expert. 3-804.

v. Notification of Rights

The examiner must inform person of the right to silence. 3-208. (See iii., above.)

Court Order

Copy of petition, order for examination, and statement of rights shall be personally delivered to respondent and provided to attorney and guardian at least 36 hours prior to time of court-ordered examination. 3-705.

vi. Required Elements of Examination

When a respondent is admitted to a mental health facility because he or she is unable to provide for basic physical needs, facility must give a comprehensive physical and mental examination and social investigation within 7 days. Purpose is to determine whether respondent's needs can be met by a program other than hospitalization. 1-119(2). Certificate must also contain examiner's clinical observations and other factual information relied upon in reaching a diagnosis. 3-602.

vii. Provision for Payment of Examiners

For an impartial examination requested by respondent, determination of the compensation of the physician, qualified examiner, clinical psychologist or other expert and its payment shall be governed by Supreme Court Rule. 3-804. No specific mention of provision for payment to mental health facility examiners.

SECTION 9 Prehearing Treatment

i. Circumstances

Emergency

Upon completion of one certificate, facility may begin treatment. But respondent is to be informed of the right to refuse treatment. If respondent refuses, treatment is not to be given unless necessary to prevent serious harm to self or others. 3-608.

Court Order

If respondent is detained for examination, treatment constraints same as Emergency, above. 3-704.

ii. Notice of Right to Refuse

See i., above.

iii. Provision for Payment

Each recipient of services, and the estate of such recipient, is liable for the payment of sums representing charges for services. If recipient or estate is unable to pay, the responsible relatives are severally liable. 5-105. Ability to pay based on gross income and number in the family. 5-116.

SECTION 10 Prehearing Dismissal/Discharge

i. Circumstances

Upon failure to get necessary examinations and certifications within required time limits, respondent is to be released immediately. 3-604, 3-607, 3-610, 3-704.

PART II: THE HEARING: DETERMINING COMMITMENT

SECTION 1 Hearing Characteristics

i. Provisions for Holding Hearings

Automatic. 3-611, 3-702.

ii. Requesting a Hearing (If Not Mandatory)

Not applicable.

iii. Notification Requirements

The court shall have notice of time and place of hearing served upon facility director, respondent, responsible relatives, and those who receive copies of the petition (attorney, guardian, and at least 2 other persons designated by respondent). 3-611, 3-706.

iv. Timing of Hearing

Emergency

Within 5 days after court's receipt of petition. 3-611.

Court Order

Within 5 days after receipt of second certificate or admission to a mental health facility, whichever is earlier. 3-706.

v. Place of Hearing

Hearings shall be held where court directs them to be. When possible, hearings should be held in mental health facility where respondent is hospitalized. Any party may request change of venue or transfer to another county as a matter of convenience or for the benefit of respondent, witnesses, or other parties. 3-800(a).

vi. Hearing Body

Circuit court. 3-100.

SECTION 2 Counsel

i. Counsel for Respondent

Every respondent shall be represented by counsel. If necessary, court shall appoint counsel. Respondent may represent self if court approves request to do so. 3-805. See Part I Section 7. Upon request, counsel also will be appointed for appeal. 3-816(b).

ii. Provision for State or County Counsel

State's attorneys of the various Illinois counties are to represent the people of the State, either in person or by assistant, in court proceedings. 3-101.

iii. Private Counsel for Petitioner or Applicant

Nothing in the Code shall prevent any party from being represented by his or her own counsel. 3-101.

iv. Role and Responsibilities of Counsel

For respondent - see Part I, Section 7 iv.

For state - represent the people of the state, attend in person or by assistant, ensure that all petitions, reports and orders are properly prepared. 3-101.

For petitioner - not specifically mentioned.

SECTION 3 Opportunity for Voluntary Admission

i. Right to Request Voluntary Admission

Any person may apply for admission to a mental health facility as an informal or as a voluntary patient. 3-300, 3-400.

Respondent may request informal or voluntary admission at any time prior to adjudication of involuntary admission. If facility director approves request, court may dismiss pending proceedings if it is in the best interest of the respondent and the public. 3-801.

Notice of this right shall be given at the end of the commitment period if facility director intends to petition for continued involuntary commitment. 3-902(b).

ii. Notice of Right

See, i., above.

iii. Relevance of Respondent's Competency

Not specifically mentioned.

iv. Approval Procedures and Conditions

See i., above.

v. Extraordinary Consequences of Voluntary Admission

After giving written notice to any treatment staff person, voluntary patient is to be discharged from facility at earliest appropriate time within 5 days, unless process is begun for involuntary commitment. 3-403.

No physician, qualified examiner, or clinical psychologist shall state to any person that involuntary admission may result if such person does not voluntarily admit himself to a mental health facility unless a physician, qualified examiner, or clinical psychologist who has examined the person is prepared to execute a certificate and the person is advised that if he is admitted upon certification, he will be entitled to court hearing with counsel appointed to represent him at which the State will have to prove that he is subject to involuntary admission. 3-402.

Thirty days after voluntary admission, and every 60 days thereafter, the patient must reaffirm the desire for continued treatment, the patient's failure to reaffirm shall constitute notice of the desire to be discharged. 3-404.

SECTION 4 Criteria for Involuntary Commitment

i. What Must Be Shown?

1) Respondent is mentally ill and, because of illness, reasonably expected to inflict serious harm on self or other in near future; or

2) Respondent is mentally ill and, because of illness, unable to provide for basic physical needs so as to guard self from serious harm. 1-119.

ii. Specific Injunctive Criteria

See i., above.

iii. Consideration of Less Restrictive Alternatives

Prior to disposition at hearing, a report shall be prepared on appropriateness and availability of alternative treatment settings. The court shall consider the report in determining an appropriate disposition. 3-810.

iv. Required Standard of Proof

Clear and convincing. 3-808.

SECTION 5 Jury Trial

i. Is the Right to Trial by Jury Provided?

Respondent has right to trial by 6-person jury. 3-802.

ii. Judicial Authority to Dismiss Jury Verdict

If respondent is found by jury to be subject to involuntary admission, and if court is not satisfied with the verdict of the jury, court may set aside jury verdict and order respondent discharged or order another hearing. 3-809.

iii. Jury Procedure Requirements

Not specifically mentioned.

SECTION 6 Procedural Issues

i. Presence of Respondent at Hearing

Respondent shall be present. Attorney may waive this right by satisfying court that attendance would subject respondent to substantial risk of serious physical or emotional harm. 3-806.

ii. Presence of Examiners at Hearing

One psychiatrist or clinical psychologist who has examined respondent must testify in person at hearing. Respondent may waive this requirement subject to court's approval. 3-807. Court may appoint one or more examiners to examine respondent and provide a detailed written report to court and to attorneys for the parties. 3-803.

iii. Presence of Other Witnesses

Not specifically mentioned.

iv. Public Access to Hearings

Not specifically mentioned.

v. Record of Hearing

Verbatim record is required of all judicial hearings. 3-817. Every final order entered by the court shall be in writing and accompanied by a statement on the record of the court's finding of fact and conclusions of law; a copy shall be given to patient or attorney and facility director. 3-816(a).

vi. Continuances

Continuances (on motion of any party) may extend up to 15 days. Continuances on request of respondent may be for longer periods. 3-800(b).

vii. Evidentiary Matters

Judicial proceedings shall be conducted in accordance with the "Civil Practices Act." 6-100.

viii. Provision for Payment

Court may assess costs against the parties, or may order State to pay costs of the proceedings. 3-818(b). Fees for jury service, witnesses and service and execution of process are the same as for similar services in civil proceedings. 3-818(a).

PART III: DETERMINING TREATMENT

SECTION 1 Adjudicating the Question of Respondent's Capacity to Refuse Treatment

i. Mandatory Part of Hearing

No. 2-101.

ii. Implicit to, But Not Independent Question of Hearing?

No recipient of services shall be presumed incompetent, nor shall such person be held incompetent except as determined by a court. 2-101.

iii. Independent Proceeding?

Competency determintion is to be separate from a judicial proceeding determining involuntary or judicial admission. 2-101.

SECTION 2 Treatment Plan

i. Required?

Facility director must prepare report for court to include "preliminary treatment plan." Treatment plan is to describe the respondent's problems and needs, the treatment goals, the proposed treatment methods, and a projected timetable for their attainment. 3-810.

ii. Timing of Treatment Plan

Report shall be prepared "before disposition." 3-810.

iii. Respondent's Right to Challenge

Patient has a right to request a court hearing to review a treatment plan. 3-814.

SECTION 3 Commitment or Order for Care or Treatment

i. Hospitalization Alternatives Specified

Hospitalization is the treatment as an inpatient by any mental health facility. 1-112. A mental health facility is any licensed private hospital, institution or facility for the treatment of the mentally ill, including all hospitals, institutions, clinics, evaluation facilities and mental health centers that provide treatment for such persons. 1-114.

ii. Less Restrictive Alternatives Specified

This Code subsection shall not affect or limit the powers of any court to order hospitalization or admission to a program of alternative treatment. 3-202. If a person is found subject to involuntary commitment, the court is to consider alternative mental health facilities. The court may order hospitalization or alternative treatment in a mental health facility. Court may order respondent to be placed in the care and custody of a relative or other person. The court shall order the least restrictive alternative for treatment which is appropriate. 3-811. Alternative treatment shall not be ordered unless program can provide appropriate, adequate, and humane treatment. 3-812.

iii. Responsibility to Consider Treatment Options

Facility director or such other person as directed by the court is to submit report to the court prior to disposition. Report shall include information on alternative treatment settings. 3-810.

iv. Judicial Authority to Mandate Admission or Specify Treatment

An order appointing a custodian shall specify the authority of the custodian. 3-815(b).

v. Provision for Payment

Provisions for liability and payment for mental health services are made in sections 5-105 through 5-116. The most important provisions are the following:

A. Each recipient of services is liable for charges for services, as well as recipient's estate and responsible relatives. Some limitations on liability exist. 5-105

B. Rules exist by which to determine the amount of liability. 5-106

C. No admission into a State facility may be limited or conditioned by recipient's ability to pay. 5-109

D. Procedures exist for petitioning for review of the determination of amount of liability. 5-111, 5-112, 5-113

E. If recipient or others cannot pay for services, the cost of services shall be borne by the State. 5-115

PART IV: POSTHEARING

SECTION 1 Notification Requirements

i. Notification of Commitment

Every final order entered by the court shall be copied and provided to respondent or his attorney and to facility director. 3-816(a).

ii. Notification of Dismissal

Not specifically mentioned.

iii. Notification of Discharge

Facility director shall give written notice of discharge to patient, attorney, and guardian. The notice shall include reason for discharge and statement of right to object. Notice shall be given at least 7 days prior to date of intended discharge whenever possible. 3-903(a).

If facility director discharges patient or changes his status, he or she is to notify the clerk of court, who is to note the action in the court record. 3-902(c). Facility director may notify the state's attorney if patient is regarded as a "continuing threat to the peace and safety of the community." In turn, the state's attorney "may notify such peace officers that he deems appropriate." 3-902(d).

SECTION 2 Appeal

An appeal may be taken in the same manner as in other civil cases. Court is to notify respondent of right to appeal and (if respondent is indigent) to right to free transcript and counsel. 3-816(b).

SECTION 3 Institutional Authority and the Role of the Court

i. Admittance

Not specifically mentioned.

ii. Treatment

Services are to be provided according to a treatment plan, which is to be provided and periodically reviewed with the participation of the "recipient" and (as feasible) recipient's nearest of kin or guardian. Plan is to be implemented by a qualified professional. 2-102(a). Restraints may be used only as therapeutic measure to prevent physical harm to self or others. A number conditions must be met in using restraints. 2-108, 2-201. Seclusion may be used only as a therapeutic

measure to prevent physical harm to self or others. A number of conditions must be met in using seclusion. 2-109, 2-201. A physician or dentist may determine that a medical or dental emergency exists, in which case essential medical or dental procedures may be performed without informed consent, if recipient is unable to give such consent. 2-111.

Within three days of admission, a treatment plan is to be prepared for the patient's record. Plan must include patient needs assessment, recommended services, goals of services, timetable to accomplish goals, and designation of responsible professional staff. Plan is to be reveiwed and updated as warranted, but at least every 30 days. 3-209.

An order appointing a custodian shall specify the authority of the custodian. The custodian shall apply to the court for permission to do anything not specified in the order. Custodian may require respondent's hospitalization only if authorized to do so by the order, and only to the facility specified in the order. 3-815(b).

iii. To Report Progress to Court

Within 30 days of admission, facility director must file treatment plan with court. Court shall review the treatment plan and may hold a hearing to review it. If court is not satisfied with patient progress, it may modify the original order or discharge patient. 3-814. If a facility director discharges patient or changes patient status, he is to notify clerk of court. Clerk of court shall enter notice into court record. 3-902(c). Within 10 days of patient death, facility director is to mail notice of death (and cause thereof) to the court. Time, place, and cause of death are to be entered on docket. Coroner's inquest is to be held in the event of sudden or mysterious death. 5-100.

iv. Transfer

Facility director may transfer patient to another facility if transfer is deemed "clinically advisable and consistent with the best needs of the patient." 3-908. If patient has been in a facility over 7 days and is to be transferred, facility director must give written notice, at least 14 days in advance of transfer, to patient, attorney, guardian, and responsible relative. 3-910(a). Patient may be transferred immediately in an emergency; and notice must be provided within 48 hours. 3-910(b). Objections to a transfer may be raised on patient's behalf, and will result in an administrative hearing. 3-910(c).

When any person is presented for admission to a mental health facility, within 7 days thereafter the facility shall provide or arrange for a comprehensive physical and mental examination and social investigation of that person. This examination shall be used to determine whether some program other than hospitalization will meet the needs of such person with preference being given to care or treatment in his own community. 1-119(2) (Applies only to those who are "presented for admission" as being unable to provide for basic physical needs.)

v. Discharge

Facility director may at any time discharge a patient who is clinically suitable for discharge. 3-902(a). Facility director is to discharge any person who is no longer "subject to involuntary admission." 3-902(b). Upon discharge or change in status of a patient, facility director shall promptly notify the clerk of court, who shall then note the action in the court record. 3-902(c). Upon discharging patient, facility director may notify state's attorney, only when patient is considered "a continuing threat to the peace and safety of the community." Upon receipt of this notification, state's attorney "may notify such peace officers that he deems appropriate." 3-902(d). Facility director may temporarily release a patient if such release is deemed clinically appropriate. 3-902(e).

SECTION 4 Patient's Rights

i. Right to Treatment

Patient shall receive adequate and humane care in the least restrictive environment, following a treatment plan that is formulated and periodically reviewed with patient's participation. 2-102(a). Patient who adheres to any well-recognized religious denomination, which calls for exclusive reliance on prayer for healing by a duly accredited practitioner thereof, has the right to choose such services. 2-102(b).

Patient has the right to request a court hearing to review a treatment plan. 3-814.

Patient (or someone on patient's behalf) may object to discharge. Administrative hearing will then be held to hear objection. 3-903(b). At such hearing, the Department bears the burden of proving that the patient should be discharged. 3-903(c).

ii. Right to Refuse Treatment

Patient shall be given the opportunity to refuse mental health services, including medication, unless such services are necessary to prevent the recipient from causing serious harm to self or others. If services are refused, they are not to be given; facility director is to inform patient or guardian of alternative services that are available, the risks of alternative services, and possible consequences of refusing such services. 2-107. No electro-convulsive therapy or any unusual, hazardous, or experimental services or psychosurgery is to be given without informed consent. 2-110. Patient has a right to request a court hearing to review a treatment plan. 3-814. Notice is to be given patient of impending transfer; it is to include notice of right to object. 3-910(a). A person may object to transfer. Objection is to be heard at administrative hearing. 3-910(c).

iii. Right to Seek Release

Any person admitted, or anyone on his or her behalf, may file a petition for discharge at any time. 3-900(a). A hearing shall be held within 5 days. 3-901(a).

Any patient (or other person on patient's behalf) may petition the court for transfer to another facility, to a program of alternative treatment, to care and custody, or to care and custody of a different person at any time. 3-909.

Patient may file writ of habeas corpus. 3-905.

iv. Personal Rights and Civil Rights

No patient is to be presumed incompetent, without determination by a court in a separate judicial proceeding. 2-101.

Person in mental health facility shall have unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation. 2-103. Restrictions to this may be used only to protect patient or other from harm, harassment, or intimidation and following notice of such restrictions. But, all communications to Governor, members of the General Assembly, Attorney General, judges, state's attorneys, officers of the Department, or licensed attorneys at law are to be sent and delivered promptly without examination by facility authorities. 2-103(c).

Patients are allowed to receive, possess and use personal property and to be provided a reasonable amount of storage space. 2-104. Patient may use his or her money as he or she chooses. No service provider shall be made a representative payee for patient's social security, pension, annuity, trust fund, or other form of payment or assistance, except in cases for which patient gives informed consent. 2-105. Patient may work if he or she consents and if it is appropriate to the mental health services being provided. Wages are to be received for such work, to be paid at least once per month. 2-106.

Every patient is to be informed orally and in writing of his (her) rights. 2-200. If any rights are restricted, notice must be given to patient and certain others and this must be entered in the patient's record. 2-201.

v. Specific Provisions

See iv, above.

vi. Patient Advocacy Systems

When a patient's status is changed, the facility director is to provide the person with the address and phone number of the Guardianship and Advocacy Commission and, if so requested, assist the patient in contacting the Commission. 3-206.

The Legal Advocacy Service (of the Guardianship and Advocacy Commission) is to

1) Make counsel available to persons in mental health judicial proceedings including those relating to admission, civil commitment, competency, and discharge.

2) Make counsel available to enforce any mental health related rights or duties coming from local, State, or Federal laws. Guardianship and Advocacy Act, 710.

SECTION 5 Retention or Recertification

i. Periods of Commitment

An initial order for treatment is for a period of 60 days or less. Prior to end of period, facility director can file 2 new certificates and new petition. He or she also must file with court the current treatment plan including description of patient's progress and benefit from treatment. After a hearing, court may order second period of treatment of 60 days or less. Third and all following periods may be for up to 180 days. 3-813 (a,b), 3-815(a).

Care and custody order is for up to 60 days. Additional periods may be up to 180 days each. 3-815. Court retains continuing authority to modify an order for alternative (non-hospital) treatment if patient fails to comply with the order or is otherwise found unsuitable for such treatment. 3-812(b). The court may revoke an order for alternative treatment and order a patient hospitalized. 3-812(c).

ii. Process for Extending Commitment Periods

For involuntary commitment, each new period of commitment is to be initiated with a new petition and two certificates of examination. 3-813.

iii. Special Procedures for Retention or Recertification Hearings

The provisions of this statute that apply whenever an initial order is sought shall apply whenever an additional period of treatment is sought. 3-813(b).

Appendix B

Rights Statements Used in Chicago

RIGHTS OF ADMITTEE

1. If you have been brought to this facility on the basis of this petition alone, you will not be immediately admitted, but will be detained for examination. You must be examined by a qualified professional within 24 hours or be released.

2. When you are first examined by a physician, clinical psychologist, qualified examiner, or psychiatrist, you do not have to talk to the examiner. Anything you say may be related by the examiner in court on the issue of whether you are subject to involuntary or judicial admission.

3. At the time that you have been certified you will be admitted to the facility and a copy of the petition and certificate will be filed with the court.

4A. If you are alleged to be subject to involuntary admission (mentally ill) you must also be examined within 24 hours excluding Saturdays, Sundays, and holidays by a psychiatrist (different from the first examiner) or be released. If you are alleged to be subject to involuntary admission the court will set the matter for a hearing.

4B. If you are alleged to be subject to judicial admission (mentally retarded) the court will set a hearing upon receipt of the diagnostic evaluation which is required to be completed within 7 days.

5A. If you are alleged to be subject to involuntary admission (mentally ill) and if the Facility Director approves, you may be admitted to the facility as a voluntary admittee upon your request any time prior to the court hearing.

The court may require proof that voluntary admission is in your best interest and in the public interest.

5B. If you are alleged to be subject to judicial admission (mentally retarded) and if the Facility Director approves, you may decide that you prefer to admit yourself to the facility rather than have the court decide whether you ought to be admitted. You may make the request for administrative admission at any time prior to the hearing. The court still may require proof that administrative admission is in your best interest and the public interest.

6. You have the right to request a jury.

7. You have the right to request an examination by an independent physician, psychiatrist, clinical psychologist, or qualified examiner of your choice. If you are unable to obtain an examination, the court may appoint an examiner for you upon your request.

8. You have the right to be represented by an attorney. If you do not have funds or are unable to obtain an attorney, the court will appoint an attorney for you.

9. You have the right to be present at your court hearing.

10. As a general rule, you do not lose any of your legal rights, benefits, or privileges simply because you have been admitted to a mental health facility (see your copy of RIGHTS OF RECIPIENTS, 79-MHDD-1). However, you should know that persons admitted to mental health facilities will be disqualified from obtaining Firearm Owner's Identification Cards, or may lose such cards obtained prior to admission.

Ref.: Section 2-200 80-MHDD-1

RIGHTS OF RECIPIENTS

Following are some of your rights. You have other rights that concern procedures of admission and discharge. These rights do not appear on these pages. However, you DO have a copy of these procedural rights; if you have admitted yourself voluntarily, look on the back of your voluntary (80-MH-2) or administrative application (80-DD-1). If you are here involuntarily, look on the back of the Petition for Admission, and also look at both sides of any court orders you have received or may receive.

RIGHTS OF RECIPIENTS OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES

RETENTION OF RIGHTS

1. As a general rule, you lose none of your rights, benefits, or privileges simply because you are a recipient of mental health or developmental disabilities services. For example, you do not lose your right to vote or to attend religious services. However, you should know that persons admitted to mental health facilities will be disqualified from receiving firearm owner's identification cards, or may lose such cards possessed prior to admission.

HUMANE CARE SERVICES PLAN

2. You are entitled to adequate and humane care and services in the least restrictive environment and an individual services plan.

MAIL/PHONE CALLS

3. You have the right to communicate with other people in private, without obtruction or censorship by the staff at the facility. This right includes mail, telephone calls, and visits.

VISITS

There are limits upon this right. They are:

(a) communication by these means may be reasonably restricted by the Director of the facility, but only to protect you or others from harm, harassment, or intimidation.

PROPERTY

4. You are entitled to receive, possess, and use personal property unless it is determined that certain items are harmful to you or others.

When you are discharged, all lawful property must be returned to you.

MONEY

5. You may use your money as you choose, unless you are under 18 or prohibited from doing so under a court guardianship order.

BANKING

You may deposit your money at a bank or place it for safe keeping with the facility. If the facility deposits your money, any interest earned will be yours.

Neither this facility nor any of its employees may act as payee to receive any payment or assistance directed to you, including Social Security and pension, annuity, or trust fund payments without your informed consent.

LABOR

6. You must be paid for work you are asked to perform which benefits the facility. But note: You may be required to do personal housekeeping chores without being paid.

REFUSING SERVICES

7. You (or your guardian on your behalf) have the right to refuse services, including medication. If you refuse, you will not be given such services, except when necessary to prevent you from causing serious harm to yourself or others.

RESTRAINTS

8. Restraints may be used only to protect you from physically harming yourself or others, or as a part of a medical/surgical procedure.

IMPORTANT INFORMATION IS ON THE BACK OF THIS FORM

SECLUSION	9.	Seclusion will only be used to prevent you from physically harming yourself or others.
UNUSUAL SERVICES	10.	You will not receive electro-convulsive therapy (electroshock) without your informed consent. Any unusual, hazardous, or experimental services require your written and informed consent.
MEDICAL OR DENTAL SERVICES	11.	Except in emergencies, no medical or dental services will be provided to you without your informed consent.
RESTRICTIONS OF RIGHTS PERSONS NOTIFIED	12.	If your rights are restricted, the facility must notify: (a) your parent or guardian, if you are under 18; (b) you and the person of your choice; (c) the Guardianship and Advocacy Commission if you say you want the Commission to be contacted.

A Guardianship and Advocacy Commission has been created which consists of three divisions: Legal Advocacy Service, Human Rights Authority and the Office of the State Guardian. The Commission is located at:

528 South Fifth Street
Springfield, IL 62706
Telephone (217) 785-1540

123 West Madison, Room 1700
Chicago, IL 60602
Telephone (312) 793-5900

YOUR RIGHTS AS A MENTAL HEALTH PATIENT AT
MANTENO MENTAL HEALTH CENTER

PROPERTY

1. You are entitled to receive, possess and use personal property unless it is determined that certain items are harmful to you and others. When you are discharged, all lawful property must be returned to you. Items that are restricted include alcohol, drugs, matches, cigarette lighters, pocket knives, sharp objects, razor blades and any item that can be used as a weapon.
2. If necessary, you or your property may be searched, in accordance with hospital policy, to insure that you are not concealing contraband.
3. Lockers are available on some areas, but staff will have keys for these lockers along with the recipient.
4. Valuables, e.g., expensive jewelry, are discouraged as staff cannot be responsible for the safekeeping of these unless the items are checked into patient's property.
5. Electrical appliances, including radios, must be consistant with regulations of the Department of Public Health.
6. You will not be allowed to operate a motor vehicle while hospitalized.

MAIL/PHONE CALLS/VISITS

1. You have the right to communicate with other people in private, in appropriately designated places, without obstruction or censorship by the staff at this facility.
2. Visiting hours are posted on each unit.
3. Pay phones are strategically located in each building in MMHC and on the facility grounds.
4. If you are without funds, two phone calls per week to the Chicagoland area will be allowed for you. These phone calls will be after 4:30 p.m. or on weekends.
5. Usage of phones is limited from 8:30 a.m. til 9:00 p.m.

MONEY

1. You may use your money as you choose unless you are under court order.
2. For your protection and convenience, money may be deposited in the Trust Fund.
3. The facility strongly encourages that recipients keep no more than $5 cash on their person.
4. The facility cannot be responsible for cash kept on your person.

REFUSING SERVICES

1. You (or your guardian on your behalf) have the right to refuse services, including medication.
2. If you refuse, you will not be given such services, except when necessary to prevent you from causing serious harm to yourself or others.
3. You may be kept under observation, however, for refusal of such services, e.g., diabetic refusing insulin, epileptic refusing anti-seizure medications, psychotic refusing phenothiazines.
4. You must also abide by commonly accepted hygienic standards as they pertain to Public Health Regulations.

The above rights were read and explained to me:

_____ BY _____
Signature Patient/Guardian Intake Worker/Case Worker

Witness _____ DATE: _____ TIME: _____ a.m. p.m.

QCS/MD
7-6-81

Copy 1 - Patient
Copy 2 - Medical Record

PATIENT'S RECEIPT OF PATIENT AND CIVIL RIGHTS INFORMATION

DATE: _____

FACILITY: Manteno Mental Health Center UNIT: _____

ADDRESS: 100 Barnard Road, Manteno, IL 60950

FACILITY REPRESENTATIVE: Dennis Headley

Upon admittance to MANTENO MENTAL HEALTH CENTER, I was told about my Patient and Civil Rights, 79 MHDD 1, so I know that if for any reason on the grounds of race, color, national origin or any handicap, I be excluded from participation in or be subjected to discrimination under any program or activity at this facility, it becomes my civil right to file a written Patient Complaint. This complaint should be addressed to the facility representative.

Also, the Mental Health Code specifies that whenever you believe that your rights are being violated, you may contact the Guardianship and Advocacy Commission. If you have a question about your legal rights, you may call:

The Guardianship and Advocacy Commission
123 West Madison Street
Chicago, Illinois 60602
AC 312 793-5900 9:00 a.m. - 5:00 p.m. Monday through Friday

_____
Signature of Patient or Responsible Relative

_____
Witnessed by

Prepare in Triplicate:
Original - Patient's File
Copy - Patient or Responsible Relative
Copy - Civil Rights Officer (Facility Representative)
Copy - Medical Records

Rev. 03/81

DERECHOS DEL PACIENTE

1. El paciente es tratado con considerachio'n, respeto y completo reconocimiento de su dignidad, individualidad, incluyendo privacidad en su tratamiento y en el cuidado de sus necesidades personales.

2. El paciente puede asociarse y comunicarse privadamente con personas de su escogencia, y enviar y recibir cartas personales sin ser abiertas, a menos que el medico lo haya contraindicado (la contraindicacio'n documentada por su me'dico).

3. El paciente tiene el derecho de obtener de su me'dico informacio'n completa y corriente en relacio'n a su diagnostico, tratamiento y prognostico en terminos de lenguage que el paciente puede entender. Cuando no es conveniente medicamente dar informacio'n al paciente, la informacio'n debe ser dada a la persona apropiada en su favor.

4. En el caso de que un procedimiento quirurjico (ciruji'a) sea necesario, el paciente debe recibir suficiente informacio'n para su consentimiento, incluyendo otras alternativas posibles para el procedimiento quirurjico. El paciente tiene el derecho de rechazar tratamiento en la extensio'n permitida por la ley y de ser informado de las consequencias medicas por su accio'n.

5. El paciente no es requerido rendir servicios a este hospital, el cual no este incluido como proposito terapeutico en su plan.

6. El paciente debe ser aseguardo tratamiento confidencial de su persona y records me'dicos, y puede aprobar o negar su entrega a cualquier individuo fuera de este hoepital, con exceptio'n, en caso de tratamiento a otra agencia o como requerido por la ley, o en el caso de contrato de pago por otra agencia.

7. El paciente, si no esta como voluntario en el hospital, tiene el derecho de un reviso frequente de su caso (que no pase un periodo de seis meses), o tener una audiencia en la corte para determinar si esta en necesidad de mas tratamiento siquiatrico. El paciente tiene el derecho de ser representado por un abogado. En cualqier procedimiento de corte, si el paciente no puede pagar a un abogado, este sera' provei'do por la corte.

8. El paciente tiene el derecho de obtener informacio'n que sea relacionado con su hospitalizacio'n a otras agencias de salud e instituciones educacionales en cuanto concierna a su cuidado. El paciente tiene derecho de obtener informacio'n concerniente de cualquiera relacio'n profesional de individuos por nombre que lo estan tratando a e'/ella.

9. El paciente tiene el derecho de ser aconsejado si el hospital propone hacer experimentacio'n humana afectando a e'l/ella en su tratamiento de cuidado. El paciente tiene el derecho de rehusar en projectos de investigaciones.

10. El paciente tiene el derecho de saber las regulaciones y reglas del hospital que aplican a su conducta como paciente. El paciente tiene el derecho de saber todos los servicios disponibles en la facilidad (hospital). Todas las cuentas por otros servicios son incluidos en la cuenta basica por di'a.

11. Cada paciente sera' transferido o descargado solamente por me'dicas por su bienestar, o de otros pacientes, y se le es dado aviso razonable, para asegurar transferencia o descarga correcta, y dichas acciones son documentadas en el record me'dico.

12. El paciente es animado y asistido a traves del periodo de hospitalizacio'n, para que ejerse sus derechos como paciente y ciudadano, y hasta este final puede dar quejas y recomendaciones para cambio de reglas y servicios de empleados en la facilidad (hospital), a tener representantes de afuera de su eleccio'n, libre de cohibicio'n, interferencia, coercio'n, descriminacio'n o represalia.

13. El paciente sera libre de abusos fi'sicos y mentales y libre de quimicos y (excepto en emergencias), amarros fi'sicos excepto autorizados en escrito por un me'dico por un especificado y limitado periodo de tiempo, o cuando sea necario de protejer al paciente de agresion a si mismo o agresion a otros.

14. El paciente puede encontrarse y participar en actividades sociales, religiosos y grupos de la comunidad a su discrecion, a menos que sea contraindicado por el me'dico (documentado por el me'dico en el record me'dico).

15. El paciente puede retener y usar sus propias ropas y poseciones como haya espacio, amenos que hacerlo pusiera en violacion los derechos de otros pacientes y amenos que sea contraindicado medicamente (como documentado por el me'dico en el record me'dico).

16. El paciente, si es casado, le es asegurado privacidad por visitas de su esposa/esposo; si los dos son pacientes en la misma facilidad (hospital), ellos son permitidos de compartir el mismo cuarto si las condiciones fi'sicas lo permiten, a menos que medicamente sea contraindicado (documentado por el me'dico en el record me'dico).

RIGHTS OF INFORMAL ADMITTEE

YOU HAVE THE RIGHT TO BE DISCHARGED FROM THIS FACILITY UPON YOUR ORAL OR WRITTEN REQUEST ANY TIME DURING NORMAL DAILY DAY SHIFT HOURS (BY LAW, NOT LESS THAN 9:00 A.M. TO 5:00 P.M.).

YOUR RIGHT TO LEAVE AT YOUR REQUEST BEGINS WITH THE FIRST DAY SHIFT AFTER ADMISSION.

AS A GENERAL RULE, YOU DO NOT LOSE ANY OF YOUR LEGAL RIGHTS, BENEFITS, OR PRIVILEGES SIMPLY BECAUSE YOU HAVE BEEN ADMITTED TO A MENTAL HEALTH FACILITY (SEE YOUR COPY OF RIGHTS OF RECIPIENTS (79-MHDD-1)). HOWEVER, YOU SHOULD KNOW THAT PERSONS ADMITTED TO MENTAL HEALTH FACILITIES WILL BE DISQUALIFIED FROM RECEIVING FIREARM OWNER'S IDENTIFICATION CARDS, OR MAY LOSE SUCH CARDS POSSESSED PRIOR TO ADMISSION.

SUMMARY OF RIGHTS

1. *You have a right to maintain all of your legal rights.*
2. *You have a right to individual services.*
3. *You have a right to unimpeded and uncensored communication.*
4. *You have a right of visitation.*
5. *You have a right to personal property.*
6. *You have a right to use your money.*
7. *You have a right to be paid for work performed.*
8. *You have a qualified right to refuse services.*
9. *You have a qualified right to be free from restraints.*
10. *You have a qualified right not to be secluded.*
11. *You have a right to protection from certain medical and dental procedures.*
12. *You have a right to see your medical record.*

Ref.: Section 2–200
79–MHDD-2

Appendix C

Data Collection Instruments

Part 1. Interview Guide

Part 2. Observation Guide

PART 1. INTERVIEW GUIDE

INVOLUNTARY CIVIL COMMITMENT PROJECT

DATA COLLECTION GUIDE

PURPOSE

The ultimate goal for this research project is to generate information by which the civil commitment process can be made to function as well as possible. The purpose of this data collection is to obtain practitioners' opinions, advice, and suggestions about the civil commitment process, particularly about the process as it operates in their own localities. Our staff has become familiar with each state's statute and basic commitment process. We know, however, that systems do not always operate exactly as statutes prescribe. Situations occasionally arise that are not explicitly provided for in statute. People who work with a system on a day-to-day basis can explain why things are done as they are and can offer insights into how a system might be made to operate most smoothly.

This research is entirely qualitative, not quantitative. Our main purpose is not to ask how many, or even how. Our purpose is to ask why, how well, and how else. Assuming that we are aware of the basic statutes and procedures, questions do not call for descriptions of legal requirements or commitment process events, per se. Descriptions of law and process are requested only to help explain advantages, disadvantages, and possible modifications of a system. We seek information about what works best and why.

APPROACH

This is not a typical research survey. The people with whom we are speaking have been chosen because they are well informed about the civil commitment process. Thus, our sample of interviewees is not a statistically representative sample; we therefore have no reason to count what percent of interviewees feel one way or the other. Our job in this research is to report on the unique and authoritative insights that these key people can impart. Because we are looking for what works best, the research has not been designed to show validly what is average or typical.

The questions in this data collection guide are open-ended. Multiple choice types of questions have been avoided so that interviewees will be free to formulate their own opinions rather than having their thoughts slotted into predetermined categories by the researchers. The only exceptions to this are the few background questions about each interviewee. Using these questions, we hope to group the interviewees into a small number of predetermined categories to help us understand how different types of people view different issues.

ORGANIZATON

This data collection guide is a complete set of all the questions that are to be investigated. People will be interviewed individually and in homogeneous groups. Some of the questions also will be answered by project staff on the basis of their own empirical observations. Project staff have a separate observation guide to help them note important events and to key the observation information to appropriate questions in this data guide.

The interview covers many topics. The complete data collection flows in a more-or-less chronolgical order, as events occur during a typical commitment process. The questions unavoidably overlap each other to some degree, but repetition was minimized as much as possible.

All the questions are coded according to the types of people whom we expect will be able to give us the desired information. The codes and their meanings are these:

J Judges, magistrates, special justices, and so on;
C Clerks and other court personnel;
L Law enforcement officers, probation officers, and so on;
A Attorneys and patients' rights advocates;
P Psychiatrists, psychologists, social workers, and so on;
R Respondent, petitioner, family members and other lay individuals;
O Direct observation.

Because of the length of the data collection guide, every question will not be asked of every interviewee. We will select a subset of questions to present in each interview, trying to optimize the match of peoples' areas of knowledge with the questions asked. Everyone will be invited, however, to discuss any aspect of the commitment process with which they are familiar or about which they have particular opinions or suggestions.

ADMINISTRATION

Whenever possible, the data collection guide will be sent to interviewees prior to the actual interview. This will give people a chance to consider the issues that are to be raised, collect their thoughts, and prepare their answers in advance, if they wish.

Questions in the data collection guide are in normal type. Text printed entirely in capitals, LIKE THIS, is meant as instruction to interviewers.

Remember that this is only a data collection guide, not a dictum. Precise language in the questions is not important, and neither is the order in which questions are covered. The guide is simply a reminder to important issues and ideas that need to be discussed. More concern is to be given to understanding the answers than to writing them down thoroughly or verbatim. Immediately following an interview, interviewers will go back through their notes to write answers fully and in proper sentences and to be sure that there are no "loose ends." If necessary, telephone calls will be made to review particular comments or to check the exact meaning of unclear answers.

In this vein, the data guide is written is conversational style. We expect the interviews to be conducted as free-flowing discussions. The information will be condensed and cast into the "King's English" during the analysis phase.

Finally, we do not necessarily expect answers to every question that is asked. We recognize that people have concerns and expertise in some areas and not in others. If interviewees do not wish to answer a particular question, the question can be skipped and the interview can progress to the next topic.

CONFIDENTIALITY

A complete statement regarding confidentiality accompanies each data collection form and is to be reviewed prior to every interview. The most important point of that statement is repeated briefly here. That is, responses to this data collection effort (or staff observations) never will be reported with reference by name to any particular individual. Anonymity of private individuals will be maintained absolutely. The anonymity of public officials will be maintained to the extent that is possible; it is acknowledged that because of their positions and special information, it may not always be possible to present information reported by public officials in a manner that would make it impossible for knowledgeable people to determine that these officials were the source of the information.

INVOLUNTARY CIVIL COMMITMENT PROJECT

Statement of Confidentiality and Project Ethics
August 28, 1981

Protecting Confidentiality

The reports that result from the information collected by interviews and observations will not identify individuals by name. Any information that reasonably could be expected to identify a private person will be deleted or disguised.

A list of public persons interviewed and the organization each represented will be included in the final report. In the report, where it is appropriate or necessary to identify comments or suggestions with an organization or person, generic descriptions will be used -- e.g., out-patient treatment personnel, attorneys, advocates, in-patient treatment personnel.

It is possible that persons knowledgeable about the mental health or legal communities could identify organizations and public persons representing them as sources of certain reported statements. We will make every reasonable effort to use multiple sources of information in order to reduce the probability of revealing the identity of particular public persons.

Information in our files will generally be deidentified. Personal identifiers will be attached to file materials only when necessary for some valid and important research purpose. We will keep all personally identifiable information in locked file cabinets. All remaining personal identifiers will be deleted or the papers destroyed at the conclusion of the project. Any requests for information that might identify an individual will be refused, unless needed for a valid and important research purpose, and then will be transmitted only after completion of a formal, written information transfer agreement, which will bind the receiver of the information, at the least, to the principles of this Statement of Confidentiality and Project Ethics.

To summarize, we will ensure the complete anonymity of private persons (patients, ex-patients, and families of same). The confidentiality of public persons and institutions will be protected to the maximum extent possible.

Research Ethics

Our staff is guided by three principles of ethical obligations:

1. We are obliged to participants in protecting their privacy and accurately representing their responses;

2. We have a duty to society, in that we do not waste funds on unnecessary research and that we make public our findings and recommendations; and

3. We are obligated to science and future researchers in conducting reliable and valid research, and documenting our methods and findings.

Informed Consent

Prior to beginning any interview or observing any non-public event for purposes of this research, one of the following statements will be read. Data collection will not occur without the expressed consent of all interview and observation subjects of this reseach (or of their guardians or responsible spokespersons).

This statement will be read prior to beginning any interview.

> We are from the National Center for State Courts. We are performing a project to help judges and mental health professionals understand and improve the process of ordering involuntary treatment for the mentally ill. We would like to ask you some questions. We greatly appreciate your help with this project. But, please understand that you may refuse to answer any questions that you wish and you may decide to stop this interview at any time. Also, you may interupt us to ask about the project at any time, and we will answer your questions as fully as we can. Our project is being done according to a written statement of confidentiality and ethics. Your interview statments will be kept entirely confidential (FOR A PUBLIC OFFICIAL ADD: to the best of our ability). Copies of information about this project and of our statement of confidentiality and ethics are available for you to read if you wish. Do you have any questions to ask before we begin the interview?

Prior to observing hearing or prehearing activities, the following statement will be read to the senior court official in the jurisdiction. If he or she so directs, it will be read to any other persons as necessary or appropriate.

> We are from the National Center for State Courts. We are performing a project to help judges and mental health professionals understand and improve the process of ordering involuntary treatment for the mentally ill. We would like the court's permission to observe hearings and other prehearing

events. We will do this with the understanding that anonymity of persons will be maintained according to the project's statement of confidentiality and ethics. At any such time as any subjects of our observations object to our presence, we agree to stop such observations immediately unless we receive your specific permission to contiue them. Copies of information about the project and of the statement of confidentiality and ethics will be available for you and any other persons to read at any time. We also will read this statment to all other persons whom you shall designate, if any. We greatly appreciate your help with this project. But, please understand that you may stop our observations at any time. Also, you and any other persons may ask questions about the project at any time, and we will answer your questions as fully as we can. Do you have any questions before we begin our observations?

Prior to any observations in or at a treatment facility, the following statement will be read to the facility director or other person with authority to consent to our project activites. If he or she so directs, it will be read to any other persons as necessary and appropriate.

We are from the National Center for State Courts. We are performing a project to help judges and mental health professionals understand and improve the process of ordering treatment for the mentally ill. We would like your permission to observe this facility and any examinations or treatment activities that are occurring, which are relevant to our work. We will do this with the understanding that anonymity of persons will be maintained according to the project's statement of confidentiality and ethics. At any such time as any subjects of our observations object to our presence, we agree to stop such observations immediately unless we receive your specific permission to contiue them. Copies of information about the project and of the statement of confidentiality and ethics will be available for you and any other persons to read at any time. We also will read this statment to all other persons whom you shall designate, if any. We greatly appreciate your help with this project. But, please understand that you may stop our observations at any time. Also, you and any other persons may ask questions about the project at any time, and we will answer your questions as fully as we can. Do you have any questions before we begin our observations?

Involuntary Civil Commitment
Master Data Guide

CHECK ONE

_____Interviewer _____

_____Observer

Date_____ City_____

Place_____

Subject of data collection. FILL APPLICABLE BLANKS

Individual interview:

Name_____

Title or Position_____

Observation:

Re Case_____

Event_____

Group interview: LIST NAME/TITLE OR POSITION

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

_____/_____ _____/_____

PROVIDE THIS INFORMATION FOR ALL SINGLE-PERSON INTERVIEWS. OTHERWISE, SKIP TO PAGE 4.

Before talking with you about specific issues, I would like to get some information about your familiarity with the commitment process and your general feelings about it.

I-1 How many years of experience have you had working in any capacity with the civil commitment of the mentally ill?_____

I-2 How would you describe your familiarity with the civil commitment statutes in this state? READ LIST OF ALTERNATIVES AND CHECK ONE BELOW.

I-3 How would you describe your familiarity with the civil commitment system and procedures in this state? READ LIST AND CHECK ONE

	I-2 Statutes	I-3 Procedures
Not at all familiar	_____	_____
Have partial or slight familiarity	_____	_____
Know well or know most	_____	_____
Know thoroughly or are expert	_____	_____

NOW DO THE INTERVIEW, BUT RETURN TO THE FOLLOWING TWO QUESTIONS AT THE VERY END.

For my final few minutes with you, I'm going to ask a couple of questions to help me summarize the way you perceive the civil commitment system in general.

I-4 I am going to read three statements about this state's present civil commitment system. Please indicate which statement you would most closely agree with. READ ALL AND CHECK ONE

_____ This state's system makes it too hard to get a person in for mental health treatment or to protect other people from the dangerous mentally ill.

_____ This state's system makes it too easy to get a person into treatment who may not really need it.

_____ This system strikes a good balance between the interests of committing a person to treatment and protecting the person's wish not to be treated involuntarily.

I-5 Similarly, I am going to read three statements about trends in your state's laws and procedures. Which one most closely reflects your feelings? READ ALL AND CHECK ONE

_____This system seems to be changing to make it <u>harder</u> to get people committed to treatment.

_____This system seems to be changing to make it <u>easier</u> to get people committed to treatment.

_____This system seems to be pretty stable in this regard.

Prehearing Section

JCL II-1 R — I would like to begin by discussing the way commitment proceedings get started. Considering the people who can initiate the process, the actions they must take to bring their complaint to the attention of the authorities, and any prepetition screening that is done...

a. What do you think are the advantages of this system?

b. What are the disadvantages?

c. What changes would you suggest, and why?

JC A O II-2

a. Do petitions and certifications usually contain all the information required in them by statute?

b. IF NO: Why not? What is lacking?

c. ALL: What other information ought to be provided, and why?

J AP O II-3 — As we understand the statute in your state, in order to initiate commitment, it is necessary to assert that respondent is mentally ill, _____ and/or _____.

a. Is this correct?

b. What else is required?

c. Are these requirements typically met in initiating commitments?

d. IF NOT: Why not?

J AP II-4

a. In your opinion, how should these requirements be altered?

JCL APR II-5 — In some places, people have worked out ways to get help for respondents before any formal hearing takes place. This can be a method for getting help without a formal commitment to treatment, or a way of avoiding the need to take the case through a formal hearing.

a. Are there any ways to do this type of prehearing diversion here?

b. IF YES: What are they, and how well do they work?

c. ALL: Can you suggest some prehearing diversions or screening procedures that are not used here now, but could be?

J L II-6 a. Once a commitment process is begun, what circumstances
AP or conditions must exist to justify taking a respondent into custody?

b. What changes, if any, would you suggest in this regard, and why?

J L II-7 a. Is there any way to avoid holding a respondent in custody
A prior to an examination or prior to a hearing?

b. IF NO: Is there any reason why this can't be done?

c. IF YES: How and when does this occur?

J L II-8 a. How, exactly, is a respondent picked up or taken into
AP custody when a commitment is initiated against him or her?

b. What are the strong points of this process?

c. What are the weak points?

J II-9 We know that states differ in their practices with regard
AP to where they hold respondents prior to an examination or hearing. As examples, some states use hospitals or local clinics exclusively, while other states allow people to be held in jails or to remain at liberty in their homes.

a. What facilities are used here to hold respondents most frequently?

b. What are the advantages to using these?

c. What are the disadvantages?

d. What other facilities might be used, and what advantages would they offer?

J II-10 a. How long are respondents typically held in custody prior
AP to receiving a hearing? PROBE FOR ANY COMMENTS ON TIME.

J L APR II-11 a. ASK THIS QUESTION ONLY IF ANSWER IS NOT ALREADY OBVIOUS FROM EARLIER QUESTIONS. Do you feel that prehearing detention practices in this system unnecessarily restrict respondent's right to liberty? Why?

b. Do you feel these practices adequately protect society from dangerous mentally ill people? Why?

c. Do you feel these practices are adequate to protect people who might be dangerous to themselves? Why?

d. What changes or procedures can you suggest to improve these practices?

J AP II-12 Let's talk a bit about mental health examinations.

a. How many examinations do respondents typically receive prior to a commitment for treatment, and when do they occur?

b. Who does the examinations?

c. What information does an examiner usually have about the respondent prior to the examination?

J APR II-13 a. Does the examination process present any special considerations in this jurisdiction with respect to the examiner and the respondent in their relationships as a doctor and patient?

b. IF YES: How are these considerations dealt with and what are the effects?

c. ALL: Is this a particular problem at time of recertification?

J AP O II-14 a. Do examination reports usually contain all the information required by law?

b. What, if any, information is <u>not</u> contained in examination reports that you think should be included? Why would it be helpful to include this information?

J AP O II-15 a. How frequently does a respondent assert or pursue a right to remain silent during an examination?

b. Is every patient informed of the likely consequences of the examination, and of the right to remain silent, if there is one?

c. IF YES: How and when is this done?

d. ALL: What effect does this have on the examination?

J AP II-16 a. How frequently do respondents request an independent examination?

b. IF EVER: When an independent examination is requested, does it seem to make a significant difference to the proceedings? IF YES: How?

c. IF NEVER: Do you feel that independent examinations should be done? IF YES: Why?

JC A O II-17 The next few questions will be addressed to the matter of respondent's attorney. These questions will be related to the entire commitment process, not just the prehearing stage.

a. Are all respondents represented by counsel?

b. IF NOT: Why are some not represented?

c. ALL: How is indigency determined?

d. What method is used for the appointment of counsel?

e. What qualifications are required for appointed attorneys?

J AP O II-18 a. What do you see as the proper role of counsel for the respondent?

b. Do attorneys tend to advocate strongly for the respondent's liberty interests in all cases, or is this true only when the attorney feels this is in the respondent's best interests?

c. How do most attorneys act with regard to these roles?

d. ALL: Do you think this should be changed, and why?

JC APR O II-19 a. Do you feel that most attorneys are sufficiently prepared in their roles as counsel for respondent?

b. IF NOT: What more should they be doing?

c. ALL: What kinds of incentives or disincentives exist for counsel to be thorough?

d. ALL: Do you think this should be changed, and why?

J AP O II-20 a. How frequently will attorneys challenge an examiner's credentials or conclusions?

b. How frequently will attorneys object to testimony or admissibility of evidence at hearing?

c. Do attorneys ever insist on psychiatrists using lay language?

d. What is the effect whenever any of these actions is done?

JC A II-21 a. Do attorneys have prompt and sufficient access to all information they need for respondent's case?

b. IF NOT: What more do they need, and how can it be provided to them?

c. ALL: Do attorneys make use of all the necessary information relating to the respondent that they have access to?

d. IF NO: What <u>important</u> information might counsel be missing, and what can be done to correct this?

JC AP O II-22 The next questions have to do with prehearing treatment.

a. Under what circumstances, if any, do respondents receive treatment prior to a formal disposition hearing?

b. What types of treatment usually are given?

c. Are respondents ever medicated when they are brought to the hearing? IF YES, ASK: Is this communicated to the court?

d. IF YES: What problems or advantages does this create?

e. ALL: What changes would you suggest?

J AP II-23 a. Do respondents ever assert a right to refuse treatment prior to disposition?

b. IF YES: What happens when respondent does so?

c. ALL: What changes would you suggest in your system with regard to respondent's right to refuse prehearing treatment and why?

JC AP II-24 a. Under what circumstances might a case be dismissed or a respondent be discharged prior to a hearing?

b. If a respondent is discharged from the custody of a mental health facility prior to a hearing, is the case automatically dismissed, or might a hearing be held anyway?

c. Do you feel that a hearing should be held, even after a person has been discharged by a mental health facility?

d. IF YES: Why and in what manner?

JCL APR O II-25 a. When and how is respondent notified of his or her rights, such as the right to counsel, to an independent examination, and to see copies of the petition and certification?

b. What more should be done, if anything, to inform respondents of their rights?

c. Are there formal procedures for waiver of rights?

CL AP II-26 a. Who is notified when a respondent is first taken into custody?

b. What notifications are made if respondent is discharged or the case is dismissed?

c. What procedure is used for giving notices?

d. What other notifications <u>ought</u> to be made?

e. Are notifications given that are unnecessary?

f. What are your practices if a respondent requests that certain people <u>not</u> be notified?

JC AP II-27 a. We are interested in the payment of the costs of prehearing procedures. Could you tell me who is responsible for these costs, who usually pays them, and whether the regulations regarding payment have any important effects on the way the following are done:

1. Picking up the respondent
2. Detention
3. Examination
4. Treatment
5. Emergency hearings

b. Who is responsible for administration and collection of payments?

JCL APR O II-28 Before going on to some questions about the hearing itself, I'd like to find out whether you have any comments to make about the early part of the process, in addition to the things we already have discussed.

a. What aspects of initiating an <u>emergency</u> commitment procedure in your system are especially helpful or problematic, and what comments or recommendations would you make about them?

b. What comments or recommendations would you care to make relating to initiating a commitment by the usual judicial hearing procedure in which no emergency is involved?

c. IF APPROPRIATE TO STATE: Would you care to make any commencs about your state's procedures for initiating a commitment that does not require judicial review?

d. What strengths or weaknesses can you comment on regarding your system's ability to use conservatorships or guardianships to get help and treatment for the mentally ill?

e. Do you care to comment on this system's procedures for initiating a commitment proceeding against a person who is currently a voluntary patient and who is seeking release?

f. What particular strengths or weaknesses, if any, does your system have for initiating a commitment for treatment for prisoners?

The Hearing: Adjudicating Commitment

JC A III-1 a. The questions in this part of the interview will focus on the hearing, per se. But first, let me ask some questions about how treatment might occur without a hearing. Excluding voluntary admission and treatment in emergency situations, is it possible for a person in this system to be committed for treatment without going through a formal hearing?

b. IF YES: How does this happen?

c. IF NO: Do you see any reason why this might be advantageous?

d. ALL: Would you suggest any changes in this regard?

JC A III-2 a. Does respondent ever have trouble obtaining a prompt hearing?

b. IF YES: What is the difficulty and how might it be overcome?

c. ALL: What period of time do you feel is needed between the filing of a petition and holding a hearing?

d. ALL: What difficulties would arise in holding the hearing prior to this time?

JC AP O III-3 a. Where are commitment hearings typically held?

b. What are the advantages and disadvantages of holding hearings there?

c. Would you suggest having the hearings somewhere else?

d. IF YES: Under what circumstances, and where?

JC APR O III-4 a. Is the respondent given an opportunity to elect voluntary admission prior to or during a hearing?

b. IF YES: Do you favor giving respondent this opportunity? Why?

c. Before permitting a respondent to choose voluntary admission, does the court consider whether the respondent has the capacity to make treatment decisions?

d. What changes would you suggest, if any, in the process of allowing for election of voluntary admission?

J AP O III-5 a. Our understanding of your civil commitment code is that a person must be found to be _____, _____ _____ and/or _____ in order to support a commitment. Is this correct? Is it interpreted this way in practice?

b. What else?

c. Are these requirements typically met?

d. What specific facts typically are presented to the court to support these criteria?

e. What changes do you think are called for in the legal criteria supporting a commitment for treatment?

J APR III-6 a. Does your system have a problem with chronically disturbed people who seem to be regularly in and out of treatment facilities? IF NO, GO TO III-7.

b. IF YES: What exactly are the nature and cause of the problem?

c. Can you suggest a solution?

JC AP O III-7 a. How, if at all, does a consideration of less restrictive alternatives enter into the hearing? That is, how, if at all, does the topic get raised and who presents testimony in this regard?

b. (ASK ONLY IF NOT OBVIOUS FROM LAST ANSWER) Does the court dismiss the case if a less restrictive alternative is identified?

c. ALL: Do you feel that adequate attention is given to less restrictive treatment alternatives in the hearing?

d. IF NOT: What more, specifically, should be done?

JC III-8 a. Do hearings typically include a state's attorney or district attorney?

b. What is the best role for state's attorney in a commitment hearing?

JC A III-9 a. How frequently does a hearing include an attorney for the petitioner?

b. What advantage or disadvantage is there in having petitioner represented by counsel?

JC A III-10a. Under what circumstances are commitment hearings held before a jury?

b. What are your feelings about jury hearings in such cases?

JC AP O III-11a. Is respondent always present at the hearing?

b. IF NO: Under what circumstances would respondent not be there?

c. ALL: What recommendations would you make about holding the hearing without respondent being present?

J O III-12a. How frequently is a person who examined respondent present to testify at a hearing?

b. IF NOT ALWAYS: How is examination evidence presented if the examiner is not present?

c. ALL: What recommendations would you make about having examiners present at hearings?

JC AP O III-13a. In practice, how strongly does the examiner's testimony or evidence influence the court and, in effect, determine the outcome of the hearing?

b. Should this be different?

c. IF YES: What can you suggest to change this?

J AP O III-14a. How frequently do psychiatrists and other examiners present a neutral assessment of respondent's condition, or how frequently do they act as advocates either for or against respondent's commitment?

b. What is the effect of this?

c. How, if at all, should this be changed?

J AP O III-15a. What other witnesses (such as petitioner) typically are at the hearings?

b. How do you feel about the effects or importance of having such witnesses at the hearings? BE SURE TO EXPLORE THIS QUESTION FOR EACH WITNESS MENTIONED IN III-15 a.

J A O III-16a. Who actually conducts the hearings, a judge or somebody else?

b. During a hearing, does the judge [OR OTHER OFFICIAL ACTING IN THIS CAPACITY] typically take an active part in directing questions to respondent and witnesses, or does the judge usually just listen as the case is presented by counsel?

c. Does this seem to be a good way to conduct the hearing? Why?

d. IF ANSWER IS NOT ALREADY OBVIOUS, ASK: What would you recommend as the best role for a judge in a commitment hearing?

JC AP O III-17a. Are hearings typically open or closed to the public?

b. What are the problems or advantages to the way your court system handles this?

JC III-18a. Does the court make a permanent record of commitment hearings? IF YES: How?

b. Is a permanent record useful or necessary? Why?

c. What additional costs are created by making a permanent record, and are the costs justified by the need?

d. What policies would you recommend for retaining or destroying civil commitment records? Why?

e. What policies ought to be followed in sealing the records and in allowing various parties to have access to these records? Why?

J A O III-19a. Under what circumstances are continuances granted?

b. What useful or harmful effects have you noticed as a result of granting continuances?

J A O III-20a. Does the court apply formal rules of procedure and rules of evidence to the commitment hearing?
Procedure_____ Evidence_____

b. What is your opinion about allowing hearsay testimony?

c. What is your feeling about allowing information about previous commitments as evidence?

d. Do you care to comment further about your system's practices regarding procedure, evidence, and testimony?

JC A O III-21 I have some further questions about notification.

a. Who is given notification of commitment hearings and at what time?

b. When, if at all, is respondent notified of the right to elect voluntary admission?

c. When, if at all, is respondent notified of the right to a jury?

d. What recommendations do you have regarding these or other notifications?

JC A III-22a. What provisions are made for paying costs associated with a hearing?

b. Who is responsible?

c. Who usually pays?

d. Do the regulations governing payments have any important effects on the way hearings are conducted?

e. What changes should be made in this regard?

f. Who is responsible for the administration and collection of payments?

Hearing: Determining Treatment

J AP O IV-1 a. During commitment hearings, is the question ever raised of respondent's capacity to make treatment decisions?

b. IF YES: Under what circumstances?

c. ALL: Is this question ever raised at a separate hearing?

d. IF YES: Under what circumstances?

e. ALL: Would you suggest any changes in practices with regard to raising this question?

f. IF YES: Why and what change?

AP IV-2 a. Is a ruling on capacity to make treatment decisions required if a person is to be committed for treament?

b. Is such a ruling required before treatment can be administered involuntarily after a person has been committed?

c. What recommendations would you make about the need to rule on this question prior to commitment and treatment? BE CAREFUL TO GET ANSWERS TO BOTH ASPECTS OF THIS QUESTION, IF YOU CAN.

J APR O IV-3 a. How customary is it for treatment plans to be presented at hearings? IF NEVER, GO TO LAST PART OF THIS QUESTION

b. Who presents the plan?

c. Are treatment plans ever challenged in the hearing?

d. IF YES: With what effect?

e. What recommendations would you care to make about the presentation of treatment plans during commitment hearings?

J AP O IV-4 a. Who, if anyone, investigates and reports to the court about treatment alternatives?

b. What people or other resources does the judge usually rely on for information about commitment options?

c. What are the advantages or disadvantages of this?

d. What changes, if any, would you suggest?

J AP O	IV-5	a.	What <u>hosptialization</u> alternatives are available to the courts?
		b.	In practice, which of these alternatives are utilized?
		c.	In ordering hospital treatment, to what extent does the court consider hospital resources and conditions?
		d.	Are other alternatives needed?
		e.	IF YES: Why, and what do you recommend?
J AP O	IV-6	a.	Does the court ever commit a respondent to a <u>nonhospital</u> treatment alternative (such as an outpatient program or into another person's care and custody)?
		b.	IF NO: Why not?
		c.	IF YES: What specific alternatives are used?
		d.	ALL: What recommendations would you make regarding commitment for treatment in a less restrictive, nonhospital setting?
J	IV-7	a.	How does a judge decide which hospital or less restrictive alternative should be chosen in a particular case?
J AP O	IV-8	a.	Does the court ever issue an order requiring a respondent to get a particular type of treatment, or requiring that treatment must be given for a specified minimum or maximum time?
		b.	What are your feelings about the court issuing such orders?
JC P O	IV-9	a.	Is a determination made of liability for payment of services when treatment is ordered? IF YES, ASK: How?
		b.	Does this determination affect the types of services made available or the procedures for obtaining services?
		c.	What changes need to be made in this regard?

Posthearing

JC A V-1 These questions will concern several issues that become important after the hearing is completed.

a. What notifications, if any, are given if a respondent is committed? IF ANY, ASK: How are notices given?

b. What notifications are given if a respondent's case is dismissed? IF ANY, ASK: How are notices given?

c. Are these notifications sufficient and useful?

d. IF NO: What changes would you suggest?

J A V-2 a. If an appeal of the commitment order is initiated, who usually begins this process?

b. Are respondents adequately informed about their right to appeal?

c. What assistance is available to respondents in bringing appeals?

d. Is the appeal process easy enough to understand and use?

e. IF NO TO b OR d, ASK: What changes would you suggest?

J A V-3 a. If an appeal is brought, how soon is it usually heard?

b. If an appeal is brought, how does this affect what happens to the respondent at the treatment facility?

c. Under what circumstances, if any, can a respondent remain at liberty following a commitment order and pending appeal?

c. Should this be changed?

J P V-4 a. After a person is ordered for treatment, what options do hospitals or alternative treatment facilities use in deciding whether or not to examine or admit for treatment?

b. Does this create any problems?

c. What benefit comes from their having those options?

d. What changes would you suggest?

J AP V-5 a. If a facility admits a patient pursuant to a court order, is it under any restrictions regarding the type or extent of treatment it may administer.

b. IF YES: What are the limitations?

c. ALL: Do you feel it is wise to place treatment constraints on a facility? Why?

d. ALL: What treatment-constraining powers should be exercised by the court (or by statute) in your opinion, and at what point in the process?

J AP V-6 a. What information, if any, does the treatment facility provide to the court to inform the court of the patient's progress?

b. IF ANY: What is the reason that this information is provided; that is, is it sent because it is required by statute, it was ordered by the court, or is it provided for some other reason?

c. What additional information does the court need, in your opinion?

d. When should such information be provided?

e. What does the court do with this information?

J APR V-7 a. In your opinion, is the court's oversight of what happens to a committed patient adequate, too much for the facility, or not demanding enough? Why?

b. What would you recommend?

J A V-8 a. What, if any, judicial sanctions are available for ensuring compliance by facilities or respondents with court orders regarding treatment?

b. How frequently are such sanctions used, and with what effect?

c. What recommendations do you have in this regard?

J APR V-9 a. What difficulties arise regarding the transfer of patients?

b. IF ANY: How could these problems be overcome?

J APR V-10 a. What difficulties arise regarding patient discharge?

b. IF ANY: How could these be overcome?

A V-11 a. How far after the hearing is court-appointed counsel responsible to the client? That is, does the client-attorney relationship continue during appeal and treatment?

b. What continuing role do you feel counsel should play following a commitment order?

AP V-12 a. Following commitment, does a patient have the right to refuse treatment? IF YES, ASK: How is the patient notified of this right?

b. Do you feel a patient should have this right?

c. IF YES TO a, ASK: What difficulties does this cause, if any, and how can they be overcome?

APR V-13 a. Under what circumstances does a treatment facility obtain informed consent prior to administering treatment to an involuntarily committed patient?

b. How does this differ for voluntary patients?

AP V-14 a. Excluding those who refuse it, are <u>all</u> patients who are admitted given some form of treatment?

b. IF NO: Why not, and what should be done about this?

APR V-15 a. In your opinion, are the civil and personal rights and safety of committed patients adequately protected?

b. IF NO: Why not, and what should be done about this?

J APR V-16 a. Do patients have access to and use a patient advocacy system to represent their interests?

b. IF NO: Why not?

c. IF YES: What makes the system useful to patients?

d. ALL: Would you recommend any changes in making an advocacy system available? (IF YES) What?

J AP V-17 a. How long are most commitment periods ordered for?

b. To the best of your knowledge, how long does the average patient actually remain in treatment?

c. To the best of your knowledge, are patients typically treated for a correct amount of time, given the help that they require?

d. Should treatment periods be longer or shorter, in your opinion, and why?

J AP V-18 a. In what ways can a patient seek a change in or release from treatment?

b. What is the most effective way?

c. Do you feel that patient's options for seeking change or release are too easy or too hard? Why?

d. What suggestions would you make concerning these avenues for treatment modification and patient release?

J APR V-19 a. Are the review hearings effective and useful? Why is this?

b. Do they differ in procedure from original commitment hearings, and how?

J AP V-20 a. Are patients' commitment periods typically extended or recertified?

b. What changes do you feel are necessary in the process for recertifying a commitment?

PART 2. OBSERVATION GUIDE

Observer_____ Date_____

City_____ Place_____

Event_____ Re Case_____

What to observe during PREHEARING PROCESSING

1. Who initiated the action? (II-1)
2. Where is the action taking place? (II-1)
3. What is being asserted about respondent? (II-3)
4. What documents and other evidence have been filed? (II-3)
5. Have all the necessary papers been filed? (II-2)
6. Do all filed papers contain all the required information? (II-2, II-3, II-14)
7. Is respondent informed of his/her rights? (II-15, II-23, II-25)
8. What options are considered and used for diversion, release, treatment? (II-5, II-7, II-9, II-22)
9. How and when is counsel appointed? (II-17, II-19, II-21)
10. Is treatment being administered? (II-22, II-23)
11. What notifications are given? (II-25, II-26)
12. Is respondent held or discharged? (II-24)

Information for observers during PREHEARING PROCESS in ILLINOIS

1. Any person over 18 may initiate an action. Peace officer or the court may initiate an emergency action based upon personal observation.

2. Except in emergency, person should be allowed to stay at home pending examination or hearing. Whenever possible, examination should be at a local mental health facility.

3. Should establish reasonable belief that person is mentally ill and either 1) expected to inflict serious harm on self or others in near future, or 2) unable to provide for basic physical needs so as to guard self from serious harm. In emergency, must also establish that immediate hospitalization is needed to protect self or others from physical harm.

4. NSM

5. Petition is required immediately. One certificate is to accompany petition immediately (another is to be filed shortly thereafter) or within 24 hours of taking into custody. If certificate is not filed immediately, statement must accompany petition certifying that 1) petitioner believes respondent to meet criteria for commitment, 2) an effort was made to get a certificate, and 3) no examiner could be found who had examined or could examine respondent.

6. Petition must include 1) detailed statement of reason for action, including description of actions and threats and their time and place of occurrence; 2) name and address of relative or friend of respondent, or statement that diligent inquiry was made to learn this information; 3) statement of petitioner's relationship to respondent and disclosure of legal or financial interests in matter or involvement in any litigation with respondent; and 4) information about witnesses by which assertions about respondent may be proved. Examiner's certificate must contain examiner's clinical observations and other factual information relied upon in reaching a diagnosis.

7. Respondent is to recieve copies of all petitions and certificates. Respondent is to be informed of his/her legal status and right to counsel and a court hearing. Prior to examination, respondent must be informed of right to remain silent during examination. After a certificate is filed, respondent must be advised of right to refuse medication. Respondent is to be asked for names of other people to whom copies of petition and certifications are to be sent. With the exception of petitions and court orders, any required statements or explanations for a patient who does not understand English must be furnished in a language he/she understands.

8. NSM

9. NSM

10. Treatment may be begun following the filing of one examiner's certificate. But, respondent must be informed of right to refuse treatment. If respondent exercises that right, treatment may not be given unless it is necessary to prevent serious harm to self or others.

11. Notification must be sent to respondent's attorney and parent(s) or guardian(s).

12. NSM

Observer_____ Date_____

City_____ Place_____

Event_____ Re Case_____

What to observe during PREHEARING EXAMINATION or TREATMENT

1. Where is the action taking place? (II-7, II-9)
2. What information is given to the examiner? (II-12)
3. What are the examiner's (treater's) qualifications? (II-12)
4. Is respondent informed of his/her rights? (II-15, II-23)
5. Does respondent refuse to cooperate with any part of the process? (II-15, II-23)
6. What information is generated about respondent? (II-14)
7. How is the report to the court formulated? (II-14)
8. What type of treatment is being given? (II-22)
9. Have statutory criteria been met to justify examination or treatment? (II-12, II-22)
10. Is respondent held or discharged? (II-24)

Information for observers during PRHEARING EXAMINATION or TREATMENT in ILLINOIS

1. Whenever possible, examination should be held at a local mental health facility.

2. NSM

3. At least one examiner (of two) must be a psychiatrist. Other examiner may be 1) a certified social worker with an MSW; 2) a registered nurse with MS in psychiatric nursing (either of these must have three years of experience and training post-degree); 3) a registered clinical psychologist with a doctoral degree and two years experience; 4) a psychologist with a graduate degree and at least six years of experience (two years of which were in the health services); or 5) a physician licensed by the state.

4. Respondent must be informed of right to remain silent during the examination and right to refuse treatment. Notification must come prior to examination and treatment, respectively. If right to refuse treatment is exercised, treatment may not be given unless it is necessary to prevent serious harm to self or others.

5. NSM

6. NSM

7. NSM

8. Restraints and seclusion are to be used only for therapeutic purposes to prevent physical harm to self or others.

9. SEE SHEET ON PREHEARING PROCESSES, ITEM 3.

10. Upon failure to get necessary examination and examiners' certificates within stated time limits, respondent is to be released immediately. First certificate must come within 24 hours of detention if not filed with petition. Second must then come prior to hearing (which is within five days). If first certificate accompanies petition, second must be filed within 24 hours.

Observer_____ Date_____

City_____ Place_____

Event_____ Re Case_____

What to observe during HEARINGS

1. Where is the action taking place? (III-3)
2. Are proper petitions and certificates available to the court? (II-2, IV-3)
3. Do all filed papers have all required information on them? (II-2, II-14)
4. Are examiners' reports available to the court? (II-2, II-14)
5. Do examiners' reports have sufficient and required information (II-2, II-14, III-7, III-12)
6. Who is conducting the hearing? (III-16)
7. What is the role of the person conducting the hearing?
   a. Does he/she direct questions? (III-16)
8. Is respondent's attorney retained or assigned? (II-17)
9. What are attorney-for-respondent's behaviors?
   a. Does he/she appear to know the facts of the case well? (II-9, II-21)
   b. Does he/she actively challenge examiners' qualifications evidence against respondent? (II-18, II-20)
   c. Does he/she seem to have all the necessary information about LRAs? (II-21, IV-4)
10. Is respondent present? (III-11)
11. Is respondent medicated? (II-22)
12. What witnesses (including examiners) testify? (II-14, II-16)

13. Is respondent informed of his/her rights? (III-4, III-21)

14. Is respondent given opportunity to elect voluntary admission? (III-4)

15. Are necessary criteria met for commitment? (III-5)

16. What rules of evidence and procedure are applied? (III-20)

17. What is examiners' influence at hearing? (III-12, III-13, III-14)

18. Is a treatment plan presented? (IV-3)

19. Are alternative treatment possibilities discussed? (IV-4, IV-5, IV-6, IV-7)

20. Who presents information on alternative treatment options? (IV-3, IV-4)

21. Is question raised of capacity to make treatment decisions? (III-4, IV-2)

22. What are the roles of attorney for petitioner and state's attorney? (III-8, III-9)

23. Is there a jury? (III-10)

24. Is the public present? (III-17)

25. Are continuances granted? (III-19)

26. Are notifications given? (III-21)

27. Are provisions made for payment? (III-22)

Information for Observers during HEARINGS in ILLINOIS

1. NSM

2. SEE SHEET ON PREHEARING, ITEM 4

3. SEE SHEET ON PREHEARING, ITEM 5

4. NSM

5. NSM

6. Hearings are under the jurisdiction of the Circuit Court.

7. NSM

8. NSM. Note, however, that statute does allow respondent to represent self, with with court's approval.

9. NSM

10. Respondent is to be present at hearings. Attorney may waive this right if court is satisfied that attendance would subject respondent to substantial risk of serious physical or emotional harm.

11. SEE SHEET ON PREHEARING, ITEM 9

12. One examiner must testify at a hearing unless respondent waives this right, subject to court approval.

13. NSM

14. Respondent has the right to request voluntary or informal admission any time prior to adjudication. If facility director approves application, the court may dismiss involuntary proceedings if court believes it to be in the best interests of respondent and the public.

15. Respondent is mentally ill and because of illness either is 1) reasonably expected to inflict serious harm on self or others in the near future, or 2) unable to provide for basic physical needs so as to guard self from serious harm.

16. Proceedings are to be conducted in accordance with the "Civil Practices Act."

17. NSM

18. Facility director is to prepare a report for the court, to include a preliminary treatment plan. Treatment plan is to describe the respondent's problems and needs, the treatment goals, the proposed treatment methods, and a projected timetable for their attainment.

19. Potential mental health facilities include private and public hospitals, institutions, clinics, evaution facilities, and mental health centers that provide treatment for the mentally ill. The court may also order the person into "care and custody" of an individual. The court is to order the least restrictive alternative for treatment that is appropriate, but not unless it can provide treatment that is appropriate, adequate, and humane.

20. NSM on presentation, but Facility Director is to prepare the report.

21. Questions of competency are not to be assumed from the adjudicaton of commitment, but, if they are to be raised, are to be decided at judicial hearings directed specifically at that issue.

22. A state's attorney is to represent the people of the State and ensure that petitions, reports, and orders are properly prepared.

23. Respondent has the right to trial by a six-person jury.

24. NSM

25. On the motion of any party, continuances may be granted for periods of up to 15 days. On respondent's request, continuances may be for longer periods of time.

26. Every final order entered by the court is to be copied and provided to respondent or his attorney and to Facility Director.

27. The court may assess costs against the parties. The court may order the State to pay the costs of the proceedings. "Fees for jury services, witnesses, and service and execution of process are the same as for similar services in civil proceedings."