This report and the study upon which it was based were made possible by grants from

THE DELLA MARTIN FOUNDATION
and
THE JOHN D. AND CATHERINE T. MACARTHUR FOUNDATION

INVOLUNTARY CIVIL COMMITMENT IN LOS ANGELES COUNTY

Ingo Keilitz
W. Lawrence Fitch
Bradley D. McGraw

Institute on Mental Disability and the Law

Published by the
National Center for State Courts
May 1982
Revised August 1982

INVOLUNTARY CIVIL COMMITMENT IN LOS ANGELES COUNTY

TABLE OF CONTENTS

PREFACE

This report describes involuntary civil commitment in Los Angeles County, California. The study upon which this report is based was part of a larger project undertaken by the Institute on Mental Disability and the Law, National Center for State Courts. Phase 1 of the project began on January 1, 1981, and lasted for eighteen months. Funding was provided by a coalition of private foundations. The major funding was provided by a grant from the John D. and Catherine T. MacArthur Foundation of Chicago. Additional grants were made by the Della Martin Foundation of Los Angeles, the Chicago Community Trust, the Columbus Foundation, the New York Community Trust, and the Winston-Salem Foundation.

This first phase has resulted in two major products. The first is a set of five site-specific volumes containing recommendations for improvement of involuntary civil commitment systems in five metropolitan areas throughout the United States: Chicago, Columbus (Ohio), New York City, Los Angeles, and Winston-Salem (North Carolina). The second product of Phase 1 is Provisional Substantive and Procedural Guidelines for Involuntary Civil Commitment, published in July 1982. This document has a national perspective but builds upon the field work and analyses undertaken in Los Angeles and the other metropolitan areas mentioned above. Together these two products comprise in excess of 800 pages of text and contain over 240 guidelines and recommendations for the improvement of involuntary civil commitment throughout the United States.

These two products are intended to be pragmatic and utilitarian. Site-specific reports, such as this document, focus primarily on the manner in which a local involuntary civil commitment system functions or should function. Each site-specific report contains observations of how statutory provisions are currently implemented, where and why practice deviates from statute, and what practices go beyond the current scope of the law. Strengths and weaknesses are identified and recommendations are made for change and improvement. Provisional Guidelines contains nationally oriented guidelines aimed at judges, court personnel, and mental health professionals in agencies allied with the courts, who work with the involuntary civil commitment process on a daily basis. The principal goal of that volume is to facilitate more efficient management of resources available to these individuals, and to facilitate the development and use of fair, simplified, and streamlined procedures for involuntary civil commitment. Great emphasis is given to practical considerations, that is, to making the implementation of existing laws workable.

Phase 2 of this project has been planned and will commence this fall, contingent upon receipt of adequate funding. During the second phase, the Institute on Mental Disability and the Law intends to put the site-specific recommendations and the provisional guidelines into the hands of those who can use them. The Phase 2 work will entail six major

elements: (1) the review, revision, publication, and dissemination of the recommendations and provisional guidelines developed in Phase 1; (2) the development of an information clearinghouse for the improvement of involuntary civil commmitment; (3) education and training of court and mental health personnel; (4) technical assistance to the courts and allied agencies; (5) demonstrations of model systems; and (6) maintaining of liaison with user groups.

ACKNOWLEDGMENTS

This report owes its existence to many people and organizations. Two foundations provided the funds to support this report and the specific research on which it is based. The Della Martin Foundation was the major contributor to our work in Los Angeles County; we are indebted to the Trustees of the Della Martin Foundation for their support. 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 four other cities: Chicago, Winston-Salem (North Carolina), New York City, and Columbus (Ohio).

The management, staff, and Board of Directors of the National Center for State Courts are acknowledged for their contributions in making this project possible. Mr. Edward B. McConnell, Executive Director of the National Center, is responsible for originating the project concept. Professor Anthony L. Guenther, of the College of William and Mary, worked as a consultant to the National Center in evaluating this concept and shaping the idea for a field research project. Members of the National Center's Board of Directors reviewed the project concept 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. Finally, Mr. Laurence K. Gould, Jr., Esq., of Sheppard, Mullin, Richter & Hampton represented The Della Martin Foundation in monitoring our work in Los Angeles. We thank him for his support.

In the early stages of the project, the research staff received substantive guidance from a remarkably informed group of people known collectively as the National Advisory Board. The individuals in this group helped define the critical research questions, sharpen the project goals, and develop research methods:

Paul Appelbaum
Professor
Law and Psychiatry Program
University of Pittsburgh
Pittsburgh, Pennsylvania

Paul Friedman
Attorney
Ennis, Friedman, Bersoff and Ewing
Washington, D.C.

B. James George, Jr.
Professor
New York Law School
New York, New York

Richard P. Lynch
Attorney and Project Director
American Bar Association
Washington, D.C.

Floyd E. Propst
Probate Judge
Atlanta, Georgia

Loren H. Roth
Professor and Director
Law and Psychiatry Program
University of Pittsburgh
Pittsburgh, Pennsylvania

Joseph Schneider (Chairman)
Judge
Circuit Court of Cook County Judge
Chicago, Illinois

David B. Wexler
Professor of Law
University of Arizona
Tucson, Arizona

Helen Wright
Past President
National Association for Mental Health
Washington, D.C.

During the field work in Los Angeles County, many individuals helped explain and demonstrate the workings of the system. Some of these people must go unnamed although they are gratefully acknowledged--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. A special debt of gratitude is owed to Paul R. Donegan, Counselor in Mental Health, Department 95, Superior Court of California, Los Angeles, and to David Guthman, Deputy District Attorney, County of Los Angeles. They introduced the project team to the important actors in the involuntary civil commitment system in Los Angeles, invited the project team to meetings with judges, provided access to facilities, people, and information, and otherwise facilitated the study at all stages. The study was made possible by their cooperation and help.

Individuals who generously gave of their time for personal and group interviews and meetings, and who offered constructive comments and suggestions after reviewing an earlier draft of this report, include:

Robert Edward Baldwin
Social Worker
Forensic Department
Metropolitan State Hospital
Norwalk

Ethel Beasley
Community Mental Health Technician
Department of Health Services
County of Los Angeles

Richard Brodkin
Attorney
Office of the Public Defender
County of Los Angeles

Jonathan B. Crane
Deputy County Counsel
County of Los Angeles

Varie Davis
Community Mental Health Technician
Department of Health Services
County of Los Angeles

Paul R. Donegan
Counselor in Mental Health
Superior Court of California
Los Angeles

J. R. Elpers
Director
Department of Mental Health
County of Los Angeles

Bruce H. Gross
Attorney and Psychologist
Institute of Psychiatry, Law
and Behavioral Science
University of Southern California

David Guthman
Deputy District Attorney
County of Los Angeles

Howard Kelner
Deputy District Attorney
County of Los Angeles

Richard W. Klink
Deputy District Attorney
County of Los Angeles

Stephen M. Lachs
Judge
Superior Court of California
Los Angeles

Barbara D. Lurie
Chief
Patients' Rights Office
Department of Mental Health
Los Angeles County

Harold E. Mavritte
Assistant Director, Programs
Department of Mental Health
County of Los Angeles

David Meyer
Head Deputy Public Defender
Office of the Public Defender
County of Los Angeles

Harry V. Peetris
Judge
Superior Court of California
Los Angeles

James Preis
Executive Director
Mental Health Advocacy Services, Inc.
Los Angeles

Dorothy Romans
Deputy Public Guardian
County of Los Angeles

Sandie Taylor
Community Mental Health Technician
Department of Health Services
County of Los Angeles

Lora Votava
Nurse and Mental Health Counselor
Olive View Medical Center
Van Nuys

Carol Warren
Associate Professor
Department of Sociology
University of Southern California

Jess Whitehill
Judge
Superior Court of California
Los Angeles

Barbara Wilson
Community Mental Health Technician
Department of Health Services
County of Los Angeles

David A. Ziskrout
Commissioner
Superior Court of California
Los Angeles

We apologize to any individuals whom we have inadvertantly neglected to acknowledge--your contributions are much appreciated.

Finally, it is fitting to acknowledge the contribution made by the project team. In addition to the authors of this report, Janice Hendryx, Lisa Russell, and Joel Zimmerman shared the tasks of studying statutes, reading articles, doing interviews and observation, and analyzing and reporting the results. Project assistants, who contributed valuable additions to the final product, were Paul Barnett and Beth Holmstrup; both were students at the Marshall-Wythe School of Law, in Williamsburg, Virginia at the time of the study in Los Angeles County.

Points of view, opinions, and recommendations advanced in this report are those of the project staff only. They do not necessarily represent official policies or positions of the Institute on Mental Disability and the Law, the National Center for State Courts; the agencies that helped fund this research; the court systems in Los Angeles County or the State of California; or any of the individuals who participated in this research or the organizations with which they are affiliated. The authors gratefully acknowledge the contributions made by these people and organizations. All responsibility for factual errors made or for opinions expressed in this report, however, rests with the authors.

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

In the interests of the readers who may first wish to review the conclusions and recommendations before studying the entire text of this report, this section provides an overview. The reader is strongly encouraged, however, to refer to the specific chapters of the report in which the bases and rationale for recommendations are discussed in detail. Out of context, and without supporting commentary, the recommendations may be misleading.

The involuntary civil commitment process in Los Angeles County can be summarized in terms of six discrete steps. These steps, corresponding to the chapters in this report, are described below in roughly chronological order; however, which procedures a particular respondent undergoes and the extent of penetration of the commitment system will depend on the type of case and, thus, the form of commitment pursued for that individual. The steps include: (1) initiating involuntary civil commitment; (2) 72-hour hospitalization for evaluation and treatment; (3) probable cause (Gallinot) hearings; (4) 14-day involuntary hospitalization; (5) continued involuntary hospitalization without a judicial hearing; and (6) judicial hearings.

Initiating Involuntary Civil Commitment

Many people have mental distresses or disabilities, and never seek professional help. The afflicted person and those around him or her may deny or learn to cope with the mental aberrations exhibited. Alternatively, the person may voluntarily admit him or herself to a private or public psychiatric hospital or community mental health center. When none of these voluntary steps are taken and when those who come in contact with the person feel hospitalization is necessary, the involuntary civil commitment process may be initiated.

The ease or difficulty with which the involuntary civil commitment process can be initiated, and by whom it can be initiated, will determine, to a large extent, the number and types of cases involved in this process. It is not difficult, for example, to envision overuse (or abuse) of the civil commitment process if it is viewed as a convenient answer to interpersonal, family, and relatively mild social problems. On the other hand, limiting those who may initiate the civil commitment process to designated law enforcement and mental health officials, as is done in Los Angeles, may restrict the number of involuntary hospitalization cases, and set high tolerance threshholds for aberrant behavior.

Most commentaries on the LPS Act and its implementation begin the review of procedures under the Act with a description of the 72-hour emergency hold for screening and evaluation, perhaps with only a brief mention of those persons authorized to initiate such holds and of what criteria they are to apply. That is, the commentaries limit description of the beginnings of involuntary hospitalization in California to those

procedures which are outlined in California mental health law (5150 et seq. and 5200 et seq.). These commentaries fail to draw notice to the prehospitalization procedures which dramatically affect the nature and frequency of involuntary commitment. Overstated, what occurs outside the hospital and courtroom is considered either unimportant or not malleable. Given what we would consider a major impart of prehospitalization procedures on the number and types of cases before Department 95, these procedures are not paid the attention they deserve.

The pre-hospitalization procedures and those persons that effect them (e.g., the petitioner or applicant for 72-hour emergency holds) are relatively invisible to the judge, public defenders, district attorneys, and mental health counselors. The gatekeepers to the involuntary hospitalization system, (police and members of the PET teams) rarely testify in court and make their views known to the judge. Insofar as the court's decisions concerning release from involuntary hospitalization are related to the functioning of a person within the community at the time of custody-taking and involuntary confinement, at least as much as they relate to a person's functioning within the mental health system once involuntary hospitalization has begun, the personnel of Department 95 should endeavor to make these pre-hospitalization procedures more visible and should accord them more weight.

RECOMMENDATION: THE COURT SHOULD BECOME FAMILIAR WITH THE IDENTITIES AND THE METHODS OF OPERATION OF THE COMMUNITY PORTALS AND GATEKEEPERS FOR INVOLUNTARY COMMITMENT AT THE PRE-HOSPITALIZATION STAGE. FURTHER, THE COURT SHOULD USE ITS INFLUENCE TO FOSTER A UNIFORM POLICY OF IMPLEMENTATION FOR INITIATING EMERGENCY TREATMENT AND EVALUATION.

RECOMMENDATION: COURT PERSONNEL (THE JUDGE, DISTRICT ATTORNEYS, PUBLIC DEFENDERS, AND MENTAL HEALTH COUNSELORS) SHOULD OCCASIONALLY MEET WITH THOSE PERSONNEL SPECIALLY DESIGNATED TO TAKE ALLEGEDLY MENTALLY DISTURBED PERSONS INTO CUSTODY FOR EMERGENCY TREATMENT AND EVALUATION. IDEALLY, THE PROCEDURES FOR CUSTODY-TAKING AND CRISIS INTERVENTION SHOULD BE PERIODICALLY OBSERVED BY COURT PERSONNEL.

A number of factors and procedures operate to screen and divert persons in Los Angeles County from involuntary detainment and hospitalization, thereby, arguably, protecting their liberty interests. Only specially authorized officials can evaluate and decide to detain allegedly mentally disordered persons for evaluation and treatment. Entry into the involuntary civil commitment system is funneled through community mental health centers. A shortage of beds in Los Angeles County effectively blocks all but the most serious cases from involuntary hospitalization. Finally, a significant proportion of the potential candidates for involuntary hospitalization are screened and diverted to outreach programs or other community services by PET teams and other gatekeepers.

There is obviously less curtailment of liberty for most of those individuals successfully diverted from involuntary detainment. The screening procedures and other factors serving to block the route to involuntary hospitalization, when successful in diverting mentally disturbed individuals from the involuntary civil commitment system to some other appropriate form of help, embody the best intents of law and mental health practice by providing treatment in the least restrictive environment that is least disruptive of family, social, and economic ties. Screening mechanisms also seem to be extremely beneficial for cost-containment. In the absence of screening and diversion (assuming even very conservative estimates of the number of people diverted from involuntary hospitalization), it is likely that hospital and judicial costs would soar.

RECOMMENDATION: GATEKEEPERS (PET TEAM MEMBERS, DESIGNATED PUBLIC AND PRIVATE MENTAL HEALTH PERSONNEL, AND DESIGNATED LAW ENFORCEMENT OFFICIALS) SHOULD BE ENCOURAGED TO OUTLINE AND COMMUNICATE TO THE COURT THE POLICIES, PROCEDURES, CRITERIA, AND OPERATIVE STANDARDS FOR SCREENING AND EVALUATION IN CRISIS INTERVENTION WITH ALLEGEDLY MENTALLY DISTURBED PERSONS IN LOS ANGELES COUNTY.

RECOMMENDATION: THE COURT, IN THE ROLE OF A REGULATORY OR ADMINISTRATIVE UNIT OF THE MENTAL HEALTH JUDICIAL SYSTEM, SHOULD REVIEW THE PREHOSPITALIZATION SCREENING AND EVALUATION POLICIES AND PROCEDURES IN LOS ANGELES COUNTY, AND FOSTER THE ADOPTION OF A SOUND AND CONSISTENT SET OF POLICIES AND PROCEDURES. THE COURT SHOULD ASSUME A LEADERSHIP ROLE IN REVIEWING REPRESENTATIVE SAMPLES OF APPLICATIONS FOR 72-HOUR DETENTION FOR EVALUATION AND TREATMENT, AND SHOULD ADVISE AUTHORIZED APPLICANTS ABOUT RECOMMENDED INFORMATION TO BE CONVEYED IN SUCH APPLICATIONS.

The custody-taking and involuntary detainment of allegedly mentally disordered persons by mobile PET teams in Los Angeles are praiseworthy. The effect of a police uniform and the use of a police cruiser in taking custody of mentally disturbed individuals are neither clearly defined nor understood very well in Los Angeles, or elsewhere for that matter. On the one hand, the perceived authority associated with the police uniform and the marked cruiser may facilitate taking a violent person into custody. On the other hand, the same uniform and marked police cruiser may be a conspicuous symbol of a physical and psychological disruption in the life of a mentally disturbed person. A PET team, especially a mobile pair consisting of a mental health worker and a peace officer, seems to strike a good balance, especially when involuntary hospitalization is viewed by the community as only one consequence of crisis intervention by the team. The procedure in Los Angeles of transporting persons alleged to be fit subjects for involuntary commitment to the hospital by means of ambulance is unique. Just as

handcuffs and a police cruiser may be symbols of criminal arrest, an ambulance may appropriately signify mental health or medical intervention.

RECOMMENDATION: THE COURT SHOULD USE ITS INFLUENCE TO ENCOURAGE THE DEVELOPMENT, THROUGHOUT LOS ANGELES COUNTY, OF MOBILE PSYCHIATRIC EVALUATION TEAMS (PET) CAPABLE OF RAPID-RESPONSE CRISIS INTERVENTION ON A 24-HOUR BASIS, AND CUSTODY-TAKING AND INVOLUNTARY DETAINMENT BY MEANS OF A MOBILE POLICE OFFICER-COMMUNITY MENTAL HEALTH TECHNICIAN TEAM WHEN APPROPRIATE.

RECOMMENDATION: BECAUSE THE NON-EMERGENCY PROCEDURES PROVIDED IN SECTION 5200 ET SEQ. ARE GENERALLY UNUSED IN LOS ANGELES COUNTY, AND BECAUSE THIS SECTION PRESCRIBES SAFEGUARDS FOR RESPONDENTS DURING THE PRE-HOSPITALIZATION STAGE OF INVOLUNTARY CONFINEMENT (E.G., CONSIDERATION OF PRIVACY AND DIGNITY, RIGHT TO BE ACCOMPANIED TO PLACE OF EVALUATION BY RELATIVE, PRECAUTIONS TO SAFEGUARD PERSONAL PROPERTY), THE COURT SHOULD ENSURE THAT THE APPLICABLE SAFEGUARDS OF THIS SECTION ARE PART OF THE CURRENT PRE-HOSPITALIZATION PRACTICES.

Emergency Hospitalization for Evaluation and Treatment

Perhaps due to the sheer number of factors potentially serving as checks and balances--mental health screening and evaluation, opportunities for release and diversion from involuntary detainment, and mental health intervention in the form of treatment and discharge planning--to be met during the relatively short 72-hour initial involuntary detention period, involuntarily detained persons in California, relatively speaking, may be better off (in terms of liberty and treatment) than their counterparts in other states during the initial period of involuntary hospitalization. Although many states provide judicial review and appointment of counsel much earlier in the process than provided for in LPS, only a few jurisdictions throughout the country (e.g., Ohio and Connecticut) make such provisions within three days of involuntary hospitalization. Thus, without considerations of the quality and validity of the procedures and events, the sheer number of mental health screenings, evaluations, and opportunities to assess the person's condition against the LPS criteria during the initial 72-hour period of confinement are meritorous aspects of the involuntary civil commitment process in Los Angeles County.

Certainly, even though no statutory provision is made for judicial review or appointment of counsel during this initial period of involuntary detention, the practice in Los Angeles County seems to comport with the legislative intent of LPS to provide prompt evaluation and treatment (5001). The ultimate judgment concerning whether the

informal screenings performed by county-designated gatekeepers, together with the mental health screenings and evaluations described in this chapter, can effectively protect the liberty interests of persons involuntarily detained for 72-hour holds may be less a matter of fact and logic than it is a matter of values that needs definition by legislative directive (see Chapter IV).

Speaking generally (and having already stated that the 72-hold in the Los Angeles process is worthy of some praise) we conclude from our study of the legal requirements, procedures, and events occurring during the 72-hour emergency hospitalization for evaluation and treatment that the court fails to take sufficient notice of the occurrences during this initial period of confinement, just as it fails to take adequate notice of the pre-hospitalization stage of involuntary civil commitment.

RECOMMENDATION: THE COURT SHOULD MAKE MUCH GREATER USE OF THE INFORMATION THAT IS ACQUIRED IN THE MENTAL HEALTH EXAMINATIONS OF PERSONS INVOLUNTARILY DETAINED FOR 72-HOUR EMERGENCY EVALUATION AND TREATMENT.

RECOMMENDATION: ALONG WITH THE NOTICE OF CERTIFICATION FOR AN ADDITIONAL 14 DAYS OF INTENSIVE TREATMENT, THE COURT SHOULD ALSO RECEIVE INFORMATION ABOUT THE CONDUCT AND OUTCOMES OF ALL SCREENINGS AND MENTAL HEALTH EXAMINATIONS PERFORMED DURING THE 72-HOUR DETENTION, INCLUDING THE ADMISSION SCREENING, EXAMINATIONS PERFORMED BY THE HOSPITAL TREATMENT TEAM DURING THE 72-HOUR PERIOD, AND THE EVALUATION RESULTING IN THE CERTIFICATION FOR 14-DAY INTENSIVE TREATMENT.

LPS does not provide a person the right to remain silent during mental health examinations, nor does it require that examiners disclose the purpose, nature, and consequences of the examination process. In our opinion, whenever permitted by the patient's mental condition, a full and open disclosure of the purpose, nature, and consequences of the examination in the context of the involuntary hospitalization process is dictated by the ethical codes of psychiatrists, psychologists, and social workers alike, regardless of the requirements of law. In fairness, persons should be satisfied in their desire to know what is happening to them and why. In our experiences in other jurisdictions, few examiners, regardless of their attitudes, report that few persons refuse to talk to them as a matter of a legal right, although many refuse because they are either too hostile or too sick to communicate.

RECOMMENDATION: THE COURT SHOULD URGE EXAMINERS TO TAKE TIME AND CARE TO EXPLAIN TO EACH PERSON EXAMINED THE NATURE AND PURPOSE OF THE EXAMINATION, ITS PLACE IN THE INVOLUNTARY HOSPITALIZATION PROCESS, AND THE LIKELY CONSEQUENCES OF THE EXAMINATION.

The treatment of persons who are involuntarily hospitalized, especially those persons that have requested release and are awaiting judicial review of their confinement, is an issue that raises little controversy in Los Angeles County. In practice, most persons are medicated and provided other types of therapies shortly after they are admitted to the hospital. Except for their legal status, and perhaps some of the hospital staff members' trepidations about that status and related liability threats, persons involuntarily hospitalized on 72-hour holds are treated essentially the same as any voluntary patient in the hospital, all other things being equal. We consider this equity commendable.

Nonetheless, whether or not a person is medicated may have other legal, as well as therapeutic, relevance. A person who is properly medicated will often present a better appearance before the court during judicial hearings. On the other hand, medication, especially over-medication, may bias a case contesting prolonged involuntary hospitalization. Medication may cloud a person's thinking and diminish his or her ability to assist counsel. Some medication, even when properly prescribed and administered, may give a person the appearance of being mentally disturbed, which, of course, would work against him or her during a writ hearing.

RECOMMENDATION: UPON FIRST MEETING WITH CLIENTS, PUBLIC DEFENDERS SHOULD FAMILIARIZE THEMSELVES WITH THE TYPE OF TREATMENT GIVEN TO THEIR CLIENTS, ESPECIALLY WHEN THE TREATMENT CONSISTS OF MEDICATION THAT IS LIKELY TO AFFECT THE PERSON'S DEMEANOR DURING COURT HEARINGS.

The broad powers to release or convert a person to voluntary hospitalization status, in effect at any time during the 72-hour hold, is clearly a positive aspect in the Los Angeles County involuntary civil commitment system. These powers serve to safeguard against improper hospitalization. As the legal and mental health communities become less concerned with improper compulsory hospitalization and more concerned with the premature release from the hospital of persons still "warm with symptoms," the discharge and release policies of mental health facilities may have to withstand closer public scrutiny. Resource allocation, administrative burdens, and fiscal concerns may become paramount, if they are not already so, in Los Angeles County.

RECOMMENDATION: THE COURT SHOULD ENCOURAGE HOSPITAL FACILITIES TO COMMUNICATE THEIR DISCHARGE POLICIES FOR INVOLUNTARILY DETAINED PERSONS TO THE COURT, AS WELL AS TO THOSE AGENCIES EMPLOYING OFFICIALS DESIGNATED TO EFFECT INVOLUNTARY HOSPITALIZATION.

Although release from involuntary hospitalization clearly serves the liberty interest of a person, the needs for some type of mental health treatment for those released persons whose condition no longer meets LPS criteria for involuntary hospitalization yet warrants further treatment, are served by their referral to community services upon

discharge. In Los Angeles County, the linkage to continued mental health services in the community for persons released from the hospital following involuntary detainment appears to be lacking.

RECOMMENDATION: THE COURT SHOULD USE ITS INFLUENCE TO ENCOURAGE HOSPITALS TO REFER DISCHARGED PERSONS TO THE COMMUNITY MENTAL HEALTH FACILITY WHICH EFFECTED THE ORIGINAL INVOLUNTARY DETAINMENT.

Probable Cause ("Gallinot") Hearings

Judicial and mental health officials involved in decisions concerning release of involuntarily detained persons must contend with an ever-changing set of legal requirements. Moreover, the requirements may be unclear, causing confusion and making compliance difficult, if not impossible. The latest perturbation for court and mental health personnel in Los Angeles County has been caused by the decision in the case of Doe v. Gallinot (657 F.2d 1017 (1981)).

At this writing, almost six years have passed since the issue of constitutionally required mandatory reviews of involuntary civil commitment was first before the courts in the case of Doe v. Gallinot. We cannot envision a retreat from the essence of the Federal District Court's ruling and affirmation by the Ninth Circuit (486 F. Supp. 983 (C.D. Cal. 1979), aff'd, 657 F2d. 1017 (9th Cir. 1981)), that is, a probable cause determination must be afforded every allegedly gravely disabled individual in connection with a certification for involuntary intensive treatment under the LPS Act. Even if, as one deputy public defender in Los Angeles put it, the "Proposition 13 chickens are roosting again," the federal courts will probably impose requirements for probable cause determinations on the mental health system that may prove to be a costly and cumbersome burden, notwithstanding the Ninth Circuit Court's opinion on that matter (id. at 1021-1024), unless those affected by the decision become aggressively proactive in fashioning acceptable probable cause procedures in Los Angeles County.

RECOMMENDATION: MENTAL HEALTH AND STATE COURT PERSONNEL, IDEALLY ACTING IN CONCERT, SHOULD STRIVE TO FASHION PROBABLE CAUSE HEARING PROCEDURES PROACTIVELY AND NOT ONLY IN REACTION TO FEDERAL COURT DECISIONS.

Fourteen-Day Involuntary Hospitalization

During the involuntary patient's 72-hour emergency hospitalization, hospital staff evaluate the patient, provide emergency mental health services, and decide whether release or continued hospitalization is appropriate. If the decision is made to certify the respondent for further hospitalization, a number of rights accrue to the respondent, including the right to contest continued hospitalization in court.

The procedures specified by California statute and case law for the certification of patients for 14-day intensive treatment are generally sound. The requirement that more than one mental health professional participate in the certification decision is particulary praiseworthy.

That the person delivering a copy of the notice of certification to a respondent certified for intensive treatment, at the time of delivery, is required to explain to the respondent his or her legal rights, is an important feature of the California procedure. Although statute does not require a specific office to inform the certified person of his or her rights, the Office of the Mental Health Counselor has been carrying out this statutory requirement in most parts of the county. That not every patient is visited is a weakness in the Los Angeles County system for involuntary commitment. Although it may require the allocation of additional funds, it is important that measures be taken to ensure that every respondent is visited by a mental health counselor.

RECOMMENDATION: THE OFFICE OF THE MENTAL HEALTH COUNSELOR SHOULD BE PROVIDED WITH THE RESOURCES NECESSARY TO ENSURE THAT IT IS CAPABLE OF SATISFYING ITS OBLIGATION TO VISIT AND EXPLAIN RIGHTS TO EVERY INVOLUNTARY PATIENT CERTIFIED FOR INTENSIVE TREATMENT. FURTHERMORE, THE OFFICE SHOULD ESTABLISH PROCEDURES THAT WILL ENABLE IT TO SATISFY THIS OBLIGATION.

Continued Involuntary Hospitalization

Involuntary patients in California who have been certified for a 14-day period of involuntary intensive treatment beyond the initial 72-hour emergency hold may be subject to recertification for an additional 14-day period of intensive treatment if suicidal, to a 90-day postcertification period of intensive treatment if dangerous to others, or to a 30-day temporary conservatorship (which may be followed by a one-year conservatorship, renewable annually) if gravely disabled.

Apart from a few complaints that it is unduly restrictive (fails to provide for continued hospitalization of persons who show signs of dangerousness to self but who have not threatened or attempted suicide), the procedure for recertification of suicidal persons for a maximum of 14 additional days of involuntary intensive treatment is highly regarded by professionals in Los Angeles County. A number of persons, however, expressed concern that an additional recertification for even more intensive treatment (apart from conservatorship) was not available.

The requirement that allegations made by the mental health professionals signing the notice of recertification be supported by accompanying affidavits is an important feature of the procedure, given that evidence of a threat or attempted suicide is required. Finally, the availability of habeas corpus relief, regardless of whether a writ hearing was held during the original fourteen-day period, is important given the passage of time and different criteria applicable in recertification proceedings.

Postcertification for dangerousness to others is extremely unpopular in Los Angeles County, primarily because it is generally believed that it is virtually impossible to prove, beyond a reasonable doubt, that someone is dangerous to others. Indeed, the professional literature is rife with demonstrations that psychiatric predictions of future violence are wrong more often than they are right. Further, the fact that conservatorship is available as an alternative and provides for a longer period of hospitalization stands as a disincentive to pursuing postcertificaton as opposed to conservatorship. Despite this, the proposed legislation that would raise the maximum period of hospitalization on a postcertification for dangerousness to others to one year is highly controversial in Los Angeles. Given that the proposed legislation (AB 351) excepts the postcertification procedures from the requirement attaching to other involuntary hospitalization proceedings that the patient be treated, many see it merely as a convenient strategy for continuing to incarcerate persons showing criminal tendencies, rather than a procedure for assuring that persons in need of mental health treatment receive it. Further, some complain, to the extent that there is a shortage of psychiatric beds in Los Angeles County, that every bed filled by a patient who is not being treated, in effect, denies a bed to someone who might benefit greatly from hospitalization.

The procedures followed in Los Angeles County for the establishment of a temporary conservatorship are generally to be commended. The practice of physicians who apply for conservatorship investigation presenting their diagnoses and a description of the patient's behavior, indicating the appropriateness of conservatorship, provides some basis on which the court might decide whether to order a temporary conservatorship.

The procedure for establishing a temporary conservatorship is not without problems, however. The procedure of routing all conservatorship applications through the Public Guardian's Office seems to be wasteful, given that the Public Guardian apparently neither acts on, nor reformulates the application before forwarding it to the County Counsel's Office. The screening performed by the County Counsel is an important feature of this procedure. It serves to protect liberty interests of proposed conservatees and, at the same time, saves the public the cost of providing conservatorship services for indigent persons capable of providing for themselves without the assistance of a conservator.

A serious weakness in the procedure by which temporary conservatorships are created in Los Angeles County is the perfunctory review of applications for temporary conservatorship made by the court. It is the judge's responsibility to have before him or her all the pertinent facts and to review carefully petitions for temporary conservatorship before signing the court order to effect conservatorship.

RECOMMENDATION: PETITIONS FOR TEMPORARY CONSERVATORSHIP, TOGETHER WITH ACCOMPANYING DOCUMENTATION, SHOULD BE PRESENTED TO THE JUDGE IN SUCH A MANNER AS TO ENCOURAGE MEANINGFUL REVIEW. FURTHERMORE, THE JUDGE SHOULD CAREFULLY CONSIDER THE ALLEGATIONS MADE IN THE PETITION AND APPLY THE CRITERIA FOR TEMPORARY CONSERVATORSHIP TO THESE ALLEGATIONS BEFORE DECIDING WHETHER TO ORDER TEMPORARY CONSERVATORSHIP.

Although it is important that procedures exist to promote the release of temporary conservatees before the establishment of a full conservatorship if circumstances have changed such that continued conservatorship is inappropriate, the suggestion that the temporary conservatorship device frequently is used by physicians essentially to "buy" time during which to treat patients who may not be gravely disabled (as defined by law) is disturbing. Such behavior is an inappropriate avoidance of the intentions of the LPS procedures.

RECOMMENDATION: THE COURT AND ITS OFFICERS, INCLUDING THE DISTRICT ATTORNEY'S OFFICE AND THE PUBLIC DEFENDER'S OFFICE, SHOULD, BY MEMORANDUM OR OTHERWISE, INSTRUCT THE MENTAL HEALTH COMMUNITY IN LOS ANGELES COUNTY REGARDING THE APPROPRIATE USE OF TEMPORARY CONSERVATORSHIP AND SHOULD DISCOURAGE ITS USE AS A CONVENIENT MECHANISM TO EXTEND THE INVOLUNTARY TREATMENT PERIOD FOR PERSONS NOT GRAVELY DISABLED.

The investigation conducted by the Public Guardian's Office during the period of temporary conservatorship appears quite adequate and thorough. The requirement that the investigating officer investigate all available alternatives to conservatorship and recommend conservatorship only if no suitable alternative is available is in compliance with the sound principle established by a number of court cases that involuntary commitment may not occur if a less restrictive alternative is available.

The practice of scheduling conservatorship hearings approximately one week before the expiration of the temporary conservatorship is to be commended. During hearings observed by the authors, proposed conservatees in a number of cases were unable to appear on the day of their hearings for various reasons (e.g., a measles outbreak in one of the county hospitals prevented the attendance of a number of proposed conservatees; others were unavailable because the bus transporting them from the hospital broke down on the way). New hearing dates still within the thirty day period of temporary conservatorship were set for many of these proposed conservatees.

Finally, the practice in Los Angeles County relating to the initiation of a reappointment of conservatorship seems sound. The procedure of the Los Angeles County Court Clerk of maintaining a "tickler" system to provide timely notification to the conservator when a rehearing or a reappointment is due is particularly noteworthy.

Judicial Hearings

LPS involuntary hospitalization and conservatorship may entail judicial hearings at various points in the proceedings. Writ of habeas corpus hearings are available upon request to respondents certified for fourteen days of involuntary intensive treatment following the initial 72-hour detention for emergency evaluation and treatment; respondents posing an imminent suicide threat recertified for an additional fourteen days of treatment for; and respondents for whom a temporary conservatorship has been created. Further, judicial hearings are mandatory in "postcertification" proceedings concerning dangerous respondents sought to be hospitalized for ninety days beyond the initial 17 days of involuntary hospitalization (3 days for the initial involuntary detention for evaluation and treatment, plus additional 14 days for "certified" involuntary intensive treatment). Finally, a hearing also must be held before "full" LPS conservatorships may be created.

The practice in Los Angeles County of operating a court exclusively for mental health proceedings is unique and praiseworthy. Although some people in Los Angeles complain that the absence of fresh faces among the attorneys working in the court discourages the introduction of new ideas and promotes the development of a hierarchy of authority to influence the outcomes of most cases, most people would agree that this continuity of professionals results in a much higher level of competence in the area of mental health law. In other cities throughout the country in which the project team of the Institute on Mental Disability and the Law have studied commitment procedures, it was not unusual to find attorneys (and even judges) who do not understand the commitment laws by which the procedures are operated.

The District Attorney's Office practice of arranging interviews with mental health professionals scheduled to testify is to be commended. It enables the Deputy District Attorney to receive current information regarding the respondent's condition and allows him or her the opportunity to screen out cases in which continued hospitalization is inappropriate. On the other hand, the failure of attorneys in the Public Defender's Office always to meet with their clients prior to the day of the hearing is a weakness of the commitment procedure in Los Angeles County. An official from the Public Defender's Office stated that their attorneys are only able to meet with their clients the day before hearing in about fifty percent of their writ cases. Reportedly, these attorneys are able to do this when they receive the full two days advance notice required by statute. Because the Mental Health Counselors actually file the writs, the Public Defender is unable to control when notice is given. Without adequate advance notice, prehearing preparation is often impossible. The above-mentioned official suggested that the solution to the notice problem is to fund the Public Defender's Office to file the writs itself. The appropriate allocation of resources in a commitment system, however, is a difficult matter. That Public Defenders have little time or opportunity to become involved in prehearing advocacy, or

investigation of less restrictive alternatives, is cause for concern. It would be presumptuous, on the basis of our limited study, however, to recommend that the allocation be reformulated to enable the Public Defender's Office to take a larger prehearing role. Nonetheless, because of its strained resources and because of inadequate advance notice, the Public Defender's Office may be unable to provide the quality of legal counsel that the professional literature suggests is necessary.

The typical court proceeding in Department 95 itself is relatively straightforward and appears to be conducted in such a manner as to ensure that credible evidence is presented and due consideration is given to the competing interests represented. Courtroom decorum could be improved, however. The public image of the courts suffers when the officers of the court (e.g., deputy district attorneys, public defenders) make light of the proceedings to an audience of respondents and other observers. This is especially true in involuntary hospitalization proceedings, given the special sensitivity of many respondents and the emotional pressure felt by relatives of respondents in these proceedings. The long-standing policy of the Public Defender's Office prohibiting such behavior is praiseworthy. The following recommendation is intended to encourage continued enforcement of this policy not only in the Public Defender's Office but among all public offices and agencies in Los Angeles County, and to encourage other participants in the Los Angeles County mental health-judicial system to solicitously recognize the solemness of hearings conducted during the commitment process.

RECOMMENDATION: THE COURT AND ITS OFFICERS SHOULD BE SENSITIVE TO THE COURT'S PUBLIC IMAGE AND SHOULD STRIVE TO OBSERVE PROPER DECORUM DURING COURTROOM PROCEEDINGS.

The practice of the conservatorship court commissioner to frequently issue a conservatorship order of limited duration, to allow an early review of progress of the case, is to be highly commended. This practice encourages conservators to attend to their cases and assess the appropriateness of particular treatments or living arrangements made for the conservatee on a periodic basis. This is particularly important if the initial order of conservatorship provides the conservator with the power to place the conservatee in a secure facility. It is generally agreed that this power should be given to the conservator only when absolutely necessary. The authority to place a conservatee in a locked facility has potentially negative consequences in addition to the obvious curtailment of the conservatee's liberty. The conservator may feel some loss of responsibility (and corresponding loss of incentive to track the conservatee's progress) with the placement of the conservatee in a secure mental health facility. Finally, the compromise between the District Attorney's Office and the Public Defender's Office, permitting the Public Defender to waive his or her client's right to a speedy jury trial, try the case at the hearing, and recall the case for a rehearing before a jury at any time, represents an excellent solution to a difficult legal problem.

Although most commentators who have considered the question agree that it is important that the defense in a commitment proceeding have the opportunity to cross-examine members of the team treating the respondent, the use of teams of forensic examiners has obvious practical utility in Los Angeles County. The concern of many that if treating physicians were required to appear in every case, little time would be left for treatment, is difficult to rebut in a county where mental health facilities may be thirty or forty miles from the courthouse. It is important, however, that whoever testifies--treating psychiatrist or forensic examiner--has thoroughly examined the respondent and has thoroughly reviewed the respondent's records prior to testimony.

Given the reluctance of many mental health professionals to testify in court and the ineffectiveness with which some present their findings, the use of forensic examiners may have advantages. To the extent that mental health professionals responsible for appearing in court receive training in mental health law, the quality of mental health testimony may improve. Of course it can be argued, and it has been argued successfully in some jurisdictions, that all mental health professionals eligible to evaluate patients for the purpose of involuntary hospitalizaton proceedings be trained and certified in the techniques of forensic mental health evaluation. In any event, the development of a special forensic expertise among those mental health professionals specially designated to testify in court may compensate to some extent for the failure of members of the treatment team to appear in court.

CHAPTER I

INTRODUCTION

OVERVIEW OF REPORT

This report is based upon a study of the process of involuntary civil commitment in Los Angeles County, California. It is introduced in this chapter by an explanation of how the study was done, what its limitations are, and how certain terms are used in this report. That explanation is followed by a brief summary of the procedures in the commitment system as they exist in Los Angeles at this writing.

The Nature of the Study

This descriptive analysis of the practice and law for treating the mentally ill in Los Angeles County focuses on involuntary detention, hospitalization and treatment, with particular emphasis on those events occurring early in the involuntary civil commitment process that typically escape formal judicial review. The bases for the analysis are California statute and relevant case law, professional literature in law and mental health, and, especially, interviews with people who work in or with the involuntary civil commitment system in Los Angeles County and observations of the system at work.

Many references are made to sections of the California statute, the Lanterman-Petris-Short Act (LPS) (Welf. and Inst. Code Sections 5000, et seq.). This report, however, is not intended as a law review. It is aimed primarily at an audience of practitioners--judges, attorneys, court employees, mental health personnel and others involved in the involuntary civil commitment process in Los Angeles County. Conclusions and recommendations contained in the report are directed at court action, not legal tactics for defense attorneys or legal reform. Conclusions are aimed at policy and practice, not legal argument; recommendations are not contrary to existing law. Some recommendations are specific; others are general and implied in the conclusions. Reference is made to statute and some case law merely to help explain why and how the system works as it does in Los Angeles County. Interpretations of statute and case law presented in this report should not be taken as authoritative, whether presented as the interpretations of the authors or of people in the field.

Neither is this report to be taken as a scholarly analysis of issues in mental health and the law. 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 commitment, including some produced by the staff of this project. 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. 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, and we apologize in advance to the numerous authors to whom we fail to give direct credit.

This report describes how informed people, who work with civil commitment in Los Angeles County, perceive the system to work and how we perceived it during our field work. It is a report of what those involved in the system do, how 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 Los Angeles County system for civil commitment.

All that we know about the system is what we have been told by the people in Los Angeles County, supplemented by the professional literature and a relatively limited number of personal observations of its practice. When it is reported that certain events occur, 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 referees, attorneys, mental health professionals, and so on. Specific names are not used. We have attempted to maintain confidentiality. Names were removed from all data so that particular individuals could not be associated unambiguously with particular bits of information provided to us. A complete set of field notes, with names of people removed, can be obtained from the Institute on Mental Disability and the Law.

The report and its recommendations will be reviewed by many people in Los Angeles County. Nevertheless, the final responsibility for its contents rests with the staff of this project. The "Acknowledgments" (pp. vii-x) identify 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 practical knowledge about the Los Angeles County 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 have to be fixed in one direction or another, though, the final decisions have been made by project staff and it is they who must be accountable for whatever wisdom or folly is thereby created.

Limitations and Focus of this Report

Every research effort has its limitations. Those reflected in this report are 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 Los Angeles County, California, and primarily that part of the process centered in Los Angeles County Superior Court Department 95. Department 95 hears approximately 2,500 mental health cases annually, most of them involving challenges to involuntary civil commitment. The report is not meant to apply to any other parts of the State of California. Some parts of the information certainly will generalize beyond the County; 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 guidelines that might be applied nationwide.

The data for this report were gathered primarily during the latter part of 1981. The final report was released in "review draft" form in June 1982. Revisions, based upon review comments received, were completed in August 1982. 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. It seems that the longer a situation remains unchanged, the longer the report remains accurate and the greater the evidence that it had no impact.

The report relates only to allegedly or actually mentally ill adults of Los Angeles County who are in the civil commitment system. It is not meant to be accurate with reference to prisoners, minors, mentally retarded or developmentally disabled persons, "inebriates," drug abusers, or "sexual offenders" who are alleged to be mentally ill. 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.

Perspective

It seems 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. Put at its simplest, 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 their 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. 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. It is equally true that 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 elimination of all individual 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 (if at all) through the criminal, rather than the civil, justice system.

Try as one may to balance the helping attitude and the liberty attitude, many situations arise in civil commitment that bring these two attitudes into sharp conflict. While the objectives of helping people and protecting freedom are not necessarily contradictory, the two attitudes may compel contradictory procedural decisions in certain situations. 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 attitudes. Disagreements about the value of a civil commitment system frequently can be understood by 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.

Consistent with the National Center for State Court's functioning as an extension of the state court systems, that is, working on their behalf and responsive to their priorities, the Institute on Mental Disability and the Law has taken on amicus curiae, library resource, and technical assistance roles vis-a-vis the courts and their allied agencies (e.g., court clinics, public defender offices, mental health centers, law enforcement agencies, diversion programs, probation and parole departments, community corrections programs). Our perspective is probably close to that of the courts that are faced with difficult practical problems. We do not argue that this perspective is necessarily neutral, but do feel very strongly that the emphasis is squarely on the improvement of everyday practices in the entire involuntary civil commitment system, practices which are often incongruent with state statutes and mental health-law theory, and practices that must, in our view, reflect the best intents of existing law.

The commitment of an individual to an institution against his or her will is an event that brings into conflict some of our most strongly held values. Our aim in conducting studies of involuntary civil commitment procedures throughout the country is to look objectively at the specific procedures of involuntary civil commitment and to help the courts and allied agencies strike an all-important and very difficult balance. This balancing act is nothing new to courts, but it involves weighing (1) the private, individual interests (e.g., liberty) that are affected by a particular procedure or official action; (2) the community's interest in the treatment of allegedly helpless and mentally disturbed individuals; (3) the community's interest in protecting itself from those persons thought to be dangerous; and, (4) increasingly in these days of an austere economy and strained state resources, the interests of the court in not imposing undue fiscal and administrative burdens on the mental health-judicial system. The judge, in the courtroom as the trier of fact, and outside of the courtroom as an executive of the court, one unit within a complex interorganizational network comprising the mental health-judicial system, must make decisions within the context of (1) an ever-shifting array of legal requirements, (2) resource allocations which come from different sources than the justice system, and (3) a clientele that comes from a part of this interorganizational network governed by regulations, policies, and resources which overlap with and differ from those of the court. Although we look at other "actors" in the involuntary civil commitment system, our emphasis is clearly on the judge and on court action as it affects the entire involuntary civil commitment process, not just that part visible in the courtroom.

In the final analysis, the decision between liberty and state intervention in the lives of allegedly mentally disturbed persons may be based more on values and morals than on facts and logic, and entail judgments that probably need to be made by the public and legislators. Unfortunately, the people in the mental health-judicial system charged with the responsibility of deciding between forced hospitalization and freedom in individual cases do not have the luxury of waiting for legislative directives. Decisions are being made today and will continue to be made even in the absence of final judgments about the state's justification for coercive hospitalization, right to treatment, right to refuse treatment, prompt judicial review of initial detainment, and so forth. Our aim is to help those individuals who must make these difficult decisions everyday. In brief, ours is a perspective that tends to shy from ultimate questions, preferring instead to focus on everyday practice; it emphasizes court action that necessarily needs to strike a balance between competing interests; and, finally, it probably reflects a little impatience with ultimate questions. As one philosopher has quipped, philosophic problems are raised, and philosophic speculation seems to be abundant at times which do not possess the logical and practical means to solve those problems.

Terminology

Some terms that deserve special comment are used throughout this report. These comments are 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 to not use this word because of its strong negative connotations, and because the Lanterman-Petris-Short Act is thought to have abolished the concept of indefinite involuntary hospitalization. In its place, most people are using the term "hospitalization" or "confinement." 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. It has been used in previous reports produced by this project. Second, in California 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 accurate either in a system such as California's in which a patient, though committed, still retains the right to refuse treatment. Although the term "court-ordered" might be a good substitute term for "committed" in California, it is 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 to subsequently re-educate the public, so that the stigma, not the word, eventually disappears.

Three other words used in this report are "respondent", "conservatee," 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 judicial review, 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 involuntary commitment proceedings; a conservatee is a person who is the subject of a special portion of those proceedings under the Lanterman-Petris-Short Act, namely conservatorship. Generally, the report refers to the person as a "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.

The impersonal pronoun "we" is used not to keep the reader at a distance but to refer accurately to the research team, staff members of the Institute on Mental Disability and the Law, National Center for State Courts who participated in this project. They are listed by name in the Acknowledgments. The project benefited immensely from many hours of sharing knowledge, observations, notes, ideas, and opinions. As a result of the sharing process, however, it is impossible to fix responsibility

for the genesis of any of the accumulated project wisdom or folly to any single individual. The task of writing this report fell to Ingo Keilitz, Larry Fitch, and Brad McGraw, however, and it is they who bear responsibility for its accuracy.

SUMMARY OF INVOLUNTARY CIVIL COMMITMENT IN LOS ANGELES COUNTY

The involuntary civil commitment process in Los Angeles County can be summarized in terms of six discrete steps. These steps, corresponding to the chapters in this report, are described below in roughly chronological order; however, which procedures a particular respondent undergoes and the extent of penetration of the commitment system will depend on the type of case and, thus, the form of commitment pursued for that individual. The steps include: (1) initiating involuntary civil commitment; (2) 72-hour hospitalization for evaluation and treatment; (3) probable cause (Gallinot) hearings; (4) 14-day involuntary hospitalization; (5) continued involuntary hospitalization without a judicial hearing; and, (6) judicial hearings. This summary makes liberal use of the description of the mechanics of California's civil commitment statute by District Judge Warren J. Ferguson in his memorandum opinion in Doe v. Gallinot (486 F. Supp. 483 (C.D. Cal. 1979)).

Initiating Involuntary Civil Commitment

California's Lanterman-Petris-Short Act (LPS) provides for two methods of initiating commitment, an emergency and a non-emergency procedure. The non-emergency procedure, entailing the filing of a petition, is rarely used in Los Angeles County; it will be only briefly mentioned.

Emergency commitment of an allegedly mentally disordered individual is initiated when a peace officer, a member of a county-designated facility's attending staff, or other designated mental health professional takes the individual into custody and transports him or her to a county-designated and State Department of Mental Health-approved facility for 72 hours of treatment and evaluation. The person who effects the original detention must state in a written application the circumstances supporting the allegation that the person is, as a result of a mental disorder, a danger to self or others, or that he or she is gravely disabled (unable to provide for own food, clothing, and/or shelter). The 72-hour emergency treatment and evaluation period may be spent at the county-designated facility or at the state hospital. It includes weekends and holidays, unless evaluation and treatment services are not available in the facility on those days. A significant screening function is performed in Los Angeles County by Psychiatric Emergency Teams (PET), mobile community mental health teams who respond to emergencies by going into the community to evaluate a proposed respondent and who offer wide-ranging crisis intervention and possible diversion from involuntary treatment.

In a non-emergency case, any person may apply to a designated county agency alleging that a proposed respondent is a fit subject for

involuntary hospitalization. Before filing the petition with the court, the county agency must screen the petition and determine if the proposed respondent meets the commitment criteria or will accept voluntary evaluation and treatment. If not, a court order for evaluation may be obtained. If the subject refuses or fails to submit to evaluation, the court may order custody and detention for 72-hour evaluation and treatment. In Los Angeles County, this petition process is rarely used though it is allowed by statute. All cases are handled, with very few exceptions, as emergency cases upon entry into the commitment system.

72-Hour Emergency Hospitalization for Evaluation and Treatment

Not all persons who are brought to a mental health facility for emergency mental health services are admitted. Based on the application of the individual effecting the involuntary detention and an initial screening, the staff may determine the person could be better served without involuntary hospitalization. If so, the statute directs provision of "evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis."

Once a respondent is admitted, two broad-ranging, mental health evaluations will be performed. These evaluations are multi-purpose: they may result in discharge and dismissal of involuntary commitment if the respondent is found to not (or to no longer) meet commitment criteria (an unlikely result); they may constitute the basis of initial treatment, which may extend into continued periods of hospitalization (certification, recertification, postcertification, or conservatorship); and, they may constitute the basis for the facilities' "defense" of its decision for continued treatment in subsequent probable cause ("Gallinot") or habeas corpus hearings.

Involuntary detention is for evaluation and treatment. Besides certain statutory proscriptions on the most intrusive treatments, the type of treatment allowed is discretionary with the staff. There seems to be no difference in choice of treatment for voluntary and involuntary patients. Within the 72-hour period, about one-third of respondents are either completely released or are converted to voluntary status, either on an inpatient or outpatient basis.

Probable Cause Hearings

California commitment law appears to be in a critical state of flux. As the result of a United States District Court ruling, affirmed by the Ninth Circuit U.S. Court of Appeals, a state-initiated probable cause hearing has been mandated for continued hospitalization of "gravely disabled" persons beyond the 72-hour detention period (making allowance for possible holiday weekends, the prehearing period may be as long as 7 days). The details of this mandate have yet to be delineated. Its purpose is to determine probable cause for involuntary commitment beyond a 72-hour period. There are indications that less than a full-blown judicial hearing may suffice to satisfy the mandate. In Chapter IV, the legal development and recent impact of this mandate is examined, and exploration of and suggestions for implementation are presented.

14-Day Involuntary Hospitalization Beyond the 72-Hour Emergency Hold

At the termination of the 72-hour emergency hold, "certification" for an additional 14 days of involuntary treatment is accomplished when the professional staff of the treating facility files a statement which attests to the facts that (1) the person has been found to be a danger to him or herself or others, or is gravely disabled; (2) the person has been advised of, but has not accepted, voluntary treatment; and (3) the facility can provide treatment. The certification must be signed by the professional person, or his or her designee, in charge of the treating facility and by a physician, psychologist, social worker, or registered nurse who participated in the evaluation, and must be personally delivered to the person certified, his or her attorney, the public defender, the district attorney, and the State Department of Mental Health, and filed with the Superior Court. The person delivering the copy of notice of certification to the person certified for treatment must inform the latter and of his right to counsel (court appointed if necessary), and of his right to file a habeas corpus petition contesting the certification (including the meaning of the term "habeas corpus"). The 14-day certification is performed ex parte by mental health professionals (i.e., without the respondent's presence or participation) and no judicial hearing is required or held to involuntarily detain the person for the 14-day certification period. The burden to contest the certification decision or to seek habeas corpus relief rests on the respondent; it is he or she who must affirmatively initiate judicial review by habeas corpus proceedings; however, another person (e.g., public defender, relative, friend) may ask for habeas corpus on the patient's behalf.

If such judicial review is sought, the respondent must sign a request for release form and the staff of the facility must notify the Superior Court of the request. A hearing must take place within two days after the petition is filed in the Superior Court. Thus, if a patient requests judicial review on the day of certification, and if the petition is filed and a hearing scheduled on that day or the following day, five days (72 hours plus 2 days of the 14-day certification) is the minimum period of involuntary hospitalization.

Continued Involuntary Hospitalization Without Judicial Review

Two legal avenues lead to detention beyond the fourteenth (seventeenth counting the 72-hour emergency hold) day without mandatory judicial review: (1) 14-day recertification for "imminently suicidal persons", or (2) 30-day temporary conservatorship. The first avenue is effected identically to the original 14-day certification. Again, respondent-initiated habeas corpus relief is the only method for obtaining court review of the involuntary commitment. Apparently, California law limits involuntary treatment of respondents who are "only" dangerous to themselves (suicidal) to a maximum of 31 days (72-hour detention for evaluation and treatment, plus 14-day certification, plus 14-day recertification). Otherwise, the mental health system must allege, and a court must find, that a respondent is subject to "90-day

danger to others" (post) certification (a rare occurrence) or "gravely disabled" conservatorship.

Temporary conservatorship for a respondent alleged to be mentally ill and gravely disabled can be effected by an ex parte judicial order. A mandatory judicial review is held to determine whether the conservatorship should become permanent. The court bases its decision on the report of an officer providing conservatorship investigation or the recommendation (by affidavit) of the professional person in charge of the 72-hour emergency detention facility. This conservatorship automatically expires in 30 days, but may be extended for up to six months if a "regular" year-long conservatorship is sought. A conservator may place a conservatee in locations such as the conservatee's home, a board and care facility, a nursing home, or a hospital. During the conservatorship, the conservator generally controls the conservatee's property. The conservator's discretion in placing a conservatee may be limited by the court. Futhermore, the conservator must notify the court and certain individuals should the conservator decide to transfer the conservatee to a setting more restrictive than that allowed by the court order.

Judicial Hearings

In addition to the required probable cause hearing, discussed above, three hearings may be held on behalf of a respondent involved in California's civil commitment. As already mentioned, the habeas corpus hearing occurs only when a respondent, or someone on his or her behalf, requests it. It can be requested whether the respondent's detention is based on danger to self, danger to others, or grave disability. Two hearings are mandatory: if the respondent is to be detained beyond the 14-day certification period on the basis of danger to others, a hearing must be held which can result in further commitment for a 90-day period; if a "regular" conservatorship is sought, a hearing must be held, which may result in appointment of a conservator for a one-year period.

The statute requires strict and extensive notification of the respondent's right to a habeas corpus review. Any person in the mental health-judicial system is responsible for insuring that a request is acted upon. The hearing is to be held within two days of the request. A 90-day "postcertification" hearing is instituted when the treating, mental health personnel petition the court to order the additional treatment period. The hearing is to be held within four days of the filing of the petition.

A facility may hold a respondent for three days beyond the 14-day period to file a conservatorship petition. The hearing is to be held within 30 days of the petition, during which time a designated person performs an extensive investigation of the respondent's situation and alternatives to the appointment of a conservator.

Although statute fails to provide for a jury trial in habeas corpus proceedings, jury trials are available for postcertification and conservatorship hearings. In all three hearings, the right to counsel

and the right of the respondent to be present are provided. A deputy district attorney represents the state. The standard of proof for these hearings is beyond a reasonable doubt. A finding that conservatorship is the least restrictive alternative is required, but this is not a statutory requirement for the habeas corpus or postcertification determinations.

CHAPTER II

INITIATING INVOLUNTARY CIVIL COMMITMENT

Many people have mental distresses or disabilities and never seek professional help. The afflicted person and those around him or her may deny or learn to cope with the mental aberrations exhibited. Alternatively, the person may voluntarily admit him or herself to a private or public psychiatric hospital or community mental health center. When none of these voluntary steps are taken and when those who come in contact with the person feel hospitalization is necessary, the involuntary civil commitment process may be initiated.

The ease or difficulty with which the involuntary civil commitment process can be initiated, and by whom it can be initiated, will determine, to a large extent, the number and types of cases involved in this process. It is not difficult, for example, to envision overuse or abuse of the civil commitment process if it is viewed as a convenient answer to interpersonal, family, and relatively mild social problems. On the other hand, limiting those who may initiate the civil commitment process to designated law enforcement and mental health officials, as is done in Los Angeles, may restrict the number of involuntary hospitalization cases, and set high tolerance threshholds for aberrant behavior.

This chapter describes the procedures and events occurring before the first formal stage of involuntary civil commitment under the LPS Act, the 72-hour emergency evaluation and treatment in a mental hospital. These prehospitalization procedures and events, as we shall discuss in this chapter, are largely overlooked in law reviews, and often are overlooked by the courts. As suggested above, for many persons these initial procedures and events constitute the entire extent of their involvement in the involuntary civil commitment process. Many persons are screened and diverted from involuntary hospitalization, many elect to enter a hospital voluntarily, and some are discharged from the hospital shortly after arrival.

EMERGENCY AND NON-EMERGENCY COMMITMENT

Mental health law in California, like that in most states, provides two major means for initiating the involuntary hospitalization of a person alleged to be a fit subject for such an action: emergency and non-emergency. The first is characterized, and differentiated from the latter, by the need for <u>immediate</u> mental health or medical intervention, including temporary involuntary custody or detention without judicial order or approval, and often involving crisis intervention by mental health or law enforcement personnel. Non-emergency procedures require a formal petition or application to the court, judicial review of the application, and a subsequent court order for detention of the person, and some type of mental health intervention. Let us consider these two means of initiating involuntary hospitalization in Los Angeles.

Emergency Procedures

Section 5150 of the LPS Act provides for the initial 72-hour emergency custody and detention of an individual thought to be "a danger to others, or to himself or herself, or gravely disabled" as a result of mental disorder. We will leave to others the discussion and controversy about the intended, currently operative, or authoritative definitions of the terms "mental disorder," "grave disability," and "dangerousness." Based upon our observations in Los Angeles and other places throughout the country, issues of formal definition are of little consequence in the initial stages of involuntary civil commitment. Instead, common sense seems to prevail. Close tracking of statutory definitions and fine distinctions in meanings may only be made, if at all, during adversarial hearings or ex parte reviews of petitions and allegations. In the initial stages of civil commitment, people not fitting the commitment criteria often are held to do so, and people fitting the criteria are ignored, depending upon the situational and biographical contexts of the agents initiating the civil commitment process. Again, common sense and not the law seems to prevail.

According to the LPS Act, not just anyone may take an allegedly mentally disordered person into custody and detain him or her for emergency evaluation and treatment. Nor can the person be taken to just any mental health or medical facility. Only designated county personnel, as defined by state and county regulation, may take a person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation. In Los Angeles, the following class of officials (referred to as "gatekeepers" in this report) are authorized to take into custody and detain allegedly mentally disordered persons for emergency evaluation and treatment: peace officers, members of the attending staff of an evaluation facility properly designated by the county, and members of community mental health centers' mobile crisis or psychiatric emergency teams (PET). These individuals are authorized to commit a person to a designated facility if there is probable cause to believe that the person meets the LPS Act commitment criteria, that is, the person is dangerous or gravely disabled due to mental disorder. According to LPS, a designated facility can admit a person for 72-hour treatment and evaluation only upon the filing and acceptance of a written application for detention that: (1) states that the gatekeeper believes that the person meets the statutory criteria for emergency detention, and (2) specifies the circumstances that brought the allegedly mentally disturbed individual to the applicant's attention.

The gatekeepers for involuntary hospitalization are certain authorized police and mental health personnel, exclusively. This is not to say that concerned citizens within the community--relatives, friends and acquaintances of allegedly mentally disturbed persons--are helpless in effecting the emergency detention of a person. These individuals must, however, first convince an authorized gatekeeper that the person for whom forced hospitalization is sought is, indeed, a proper subject for emergency detention. One district attorney estimated that approximately 45 percent of the 72-hour "holds," as they are called in

Los Angeles, were initiated by family members, friends, neighbors, or acquaintances of the allegedly mentally disordered person. Another 45 percent were the result of initial, direct contact of police with persons acting in an aberrant manner. The remaining ten percent, again according to the estimates of one district attorney, were "holds" initiated by mental health personnel, including transfers from correctional facilities.

Whatever the legislative intent of the LPS Act in providing for designated gatekeepers for involuntary hospitalization, the restrictions on who may set emergency detention and 72-hour holds in motion serve a screening function. Given that the police and the mental health personnel, as gatekeepers, possess at least a commonsensical understanding or intuition about the condition called "mental disorder" and the behavioral components necessary to support involuntary civil commitment under LPS, it appears that to frivolously or improperly set the involuntary hospitalization procedures in motion in Los Angeles would be difficult. Informal, initial screenings are conducted by peace officers called to deal with an immediate crisis. An officer must decide whether the situation warrants his or her attention, and if so, whether the person is sufficiently mentally aberrant to warrant further action, that is, taking the person into custody, transporting the person to a hospital, and filing a formal application.

In sum, the portal in Los Angeles for emergency evaluation and treatment under Section 5150 of the LPS Act is the community mental health center. The gatekeepers are peace officers and mental health personnel, usually members of the psychiatric emergency teams (PET). Our impressions, based on observations and interviews, were that this concept of community portals and gatekeepers was generally adhered to in practice. Hospitals reportedly are reluctant to initiate and, except in compelling circumstances, will not initiate an application for emergency evaluation and treatment when no such application has previously been filed by police or community mental health center personnel. (This only describes situations, however, in which the allegedly mentally disordered person is not a patient in the hospital at the time the question of involuntary hospitalization arises. Hospitals designated to accept involuntary patients in Los Angeles will routinely initiate 72-hour holds on voluntary patients already hospitalized who they deem in need of involuntary hospitalization.)

Non-Emergency Procedures

The LPS Act allows the initiation of involuntary hospitalization in non-emergency cases by providing for evaluation and treatment by court order. Any person may apply to a designated county agency for a petition alleging that he or she has knowledge of a person who is a fit subject for involuntary hospitalization (5200 et seq.). The petition should request a professional mental health evaluation of the allegedly mentally disturbed individual (5201). Before filing the petition with the court, the county agency must screen the request to determine whether probable cause exists to believe the allegations and whether the person will accept mental health evaluation and treatment voluntarily. If the person

refuses or resists voluntary mental health evaluation, however, the county agency designated to conduct the screening process should file the petition and the screening report in the Superior Court. If it appears to the court that the person identified in the petition meets the LPS criteria of grave disability or dangerousness, the judge will issue an order commanding the person to submit to a mental health evaluation (5200-5206).

This path to court-ordered evaluation and treatment in non-emergency cases, as outlined in the LPS Act, is almost never traveled in Los Angeles. Reportedly, the process of petitioning the court for evaluation and treatment in non-emergency cases (Section 5200 et seq.) was rejected in Los Angeles after a protracted period of trial and error in the 1970s. Today, the use of petitions has all but disappeared and all involuntary hospitalizations are generally made under Section 5150 of the LPS Act. Interestingly, the demise of the petition process seemed to have no significant resistance in Los Angeles. The court decision in the case of Doe v. Gallinot, in describing the mechanics of the LPS Act, makes no mention of the petition process provided in Sections 5200 et seq. (486 F. Supp. 983 [C.D. Cal. 1979], aff'd, 657 F. 2d 1017 (9th Cir. 1981).

Reportedly, the petition process may still be used on rare occasions in controversial cases, such as, when a famous film star is involved. Typically, callers requesting a petition form are referred by the court to county mental health programs and psychiatric emergency teams (PET) in the community. Individuals may sometimes contact the court requesting a petition only after having been turned away by a community mental health center. In such cases, the court typically refuses involvement.

One public defender, echoing the views of most of the attorneys, mental health counselors, judges, and mental health personnel we interviewed, stated that the procedures under Section 5200 of the LPS Act, as written, make it virtually impossible to petition for involuntary hospitalization, and that this impossibility justifies the court's practice of ignoring this statutory provision. One might ask, however, should not the relatives, friends, or neighbors of a mentally disordered person be able to petition the state to step in to prevent needless suffering, even though an actual emergency situation may not yet exist? One mental health counselor answered, that because petitions for court-ordered evaluations, if filed, would end up in the community mental health centers for screening in any event, the petition process is a cumbersome and time-consuming procedure that does not appear to meet any need not currently met by referring petition requests directly to the community mental health centers. In sum, the practices of the community mental health centers in functioning as the portal for involuntary hospitalization, and the court referral of persons seeking to petition the state to community mental health resources, especially to the PET teams, have effectively replaced the petition procedure and court-ordered evaluation and treatment under Section 5200 of the LPS Act.

One former judge in Department 95, who favored the declining use of the petition process in Los Angeles, responded to our concern about the possibility of mentally disabled persons moving slowly towards starvation behind closed doors, as friends and relatives stand by helplessly without recourse to petition the state to intervene until an "emergency" exists. He believed that the court should not be empowered to order peace officers to break down the door of an allegedly gravely disabled person and compel him or her to submit to involuntary treatment and evaluation, solely on the basis of the allegations of persons in the community not designated to request involuntary hospitalization. He drew an analogy to criminal procedure, where a citizen's complaint normally leads to investigation, not necessarily to arrest. In misdemeanor cases, unless an offense is committed in the presence of an officer, he or she ordinarily has no authority to arrest the person. Acknowledging that decisions in such situations may be based more on values and morals than facts, this judge felt that there may be more danger in forcibly taking a person into custody than the person would present to himself (or herself) "squirreled up in his house."

This concern for the helpless and suffering persons and their relatives standing by (unable to petition the state to intervene), in fact, may be more academic than real. According to members of one PET team we interviewed, PET teams have intervened in the past, and will continue to intervene, in the lives of persons they believe to be mentally aberrant, including breaking down doors to get to a person, if the condition of the person warrants such action and if proper precautions, such as the presence of a relative or friend and police back-up, have been taken.

SCREENING AND DIVERSION FROM INVOLUNTARY HOSPITALIZATION

Contrary to the view that the LPS Act created a "funnel with a relatively large and simple entrance and increasingly narrow criteria and complex procedural requirements for every extended period of involuntary treatment" (ENKI Research Institute, A Study of California's New Mental Health Law [1969-1971], p. 17, 1972, emphasis added), the restrictions on initiating involuntary hospitalization and the number of screenings occurring before hospital admissions makes entrance to the involuntary hospitalization system all but simple. As discussed above, only specifically authorized officials may initiate involuntary hospitalization proceedings: designated peace officers, designated classes of professionals (psychiatrist and psychologists with years of experience) at designated mental health facilities, and other individuals specially designated by the county, including members of the PET teams. Further, the petition process under Sections 5200-5206 of the LPS Act allowing any individual to compel the state to intervene on behalf of a person alleged to be a fit subject for involuntary hospitalization is not in use in Los Angeles. Only designated individuals have the authority to evaluate and decide to detain allegedly mentally disordered persons for evaluation and treatment pursuant to Section 5150 of the LPS Act. The person alleged to be mentally disordered is evaluated against the LPS involuntary commitment criteria at various stages of the commitment process. The community mental health center facilities are the portals

for 72-hour emergency hospitalization for evaluation and treatment and it is through them that much screening and diversion from more prolonged involuntary hospitalization occurs.

As indicated earlier, much mental aberration is ignored and tolerated by families and communities and, thus, escapes the attention of mental health facilities or the judicial system. Screening and informal evaluation of allegedly mentally disordered persons that do come to the attention of the mental health system typically begin with a telephone referral to, or personal contact with, a local community mental health center. Los Angeles County, for purposes of involuntary hospitalization pursuant to LPS, has been divided into regions. Each region, corresponding roughly to the "catchment" areas of the major mental health hospitals in Los Angeles County, has a community facility (e.g., Martin Luther King Hospital) that is the portal for LPS commitments. Designated officials in that region, including PET team members and police, are the gatekeepers regulating entry of involuntary patients into the mental health system.

One community mental health technician and a member of a regional PET team with whom we spoke, estimated that the facility in which she worked received between 5 to 12 telephone calls per day. She said that the person receiving the call typically queries the caller about the potential patient's present mental condition and behavior, and prior mental health history. If it appears to the community mental health technician receiving the telephone referral, that the individual on whose behalf the call is being made does not meet the LPS Act criteria (the one community mental health technician whom we interviewed and who customarily received such telephone referrals was quite well versed in the LPS involuntary hospitalization criteria), the caller is referred to community outreach services. Unfortunately, we were unable to obtain estimates of the proportion of telephone referrals of potential candidates for involuntary hospitalization that are diverted to outreach programs or other services in the community.

If the community mental health technician manning the telephone identifies a likely candidate for crisis intervention and, perhaps, emergency treatment and evaluation under Section 5150 of LPS, the technician will contact the PET team in the region. PET teams operate in five regions throughout Los Angeles County. The operating procedures of the PET teams in the different regions vary considerably. For example, according to one deputy district attorney, the response times of the PET teams vary: some operate only during week days, others operate during the evening hours, and still others are more active at certain times of the year. The operation of the PET teams was derogatorily referred to as "emergencies by appointments" by several people whom we interviewed.

Members of the PET teams are designated by Los Angeles County to provide crisis intervention and to cause eligible persons to be taken into custody and placed in a mental health facility for 72-hour involuntary treatment and evaluation. Crisis intervention is broadly defined in LPS (5008(e)) as an interview or series of interviews, which

may be conducted in the home of the person, aimed at "therapy, or other services, as may be appropriate," including suicide prevention, or psychiatric, welfare, psychological, legal, or other social services. Section 5651.7 requires the counties to provide a plan, by July 1, 1981, for "extramural crisis intervention" aimed at mental health services provided in settings outside of traditional mental health facilities (e.g., in the home of the person or family) with a goal of preventing "unnecessary and costly disruption of normal living." One deputy district attorney commented that the function of the PET teams in Los Angeles effectively replaced that of the petition and court-ordered evaluation procedure under Section 5200 of LPS.

Three or four of the PET team members with whom we spoke actually ride (or "roll") with a peace officer in a police cruiser; one member of the team remains at the community mental health facility to answer telephone referrals. Reportedly, the particular PET team with whom we spoke was unique in that its members actually accompany the police in their cruisers; other teams have a county vehicle at their disposal but do not customarily accompany the police. According to the members of this team, the community mental health center made arrangements to "roll with the police" because police "backup" was required in many of the responses to crisis intervention requests. They claim that the procedure is cost-effective because it saves the increased cost of crisis intervention, referral, emergency treatment and evaluation which might be necessary once the person has been taken into custody by the police and detained in the local jail. Crisis intervention by the PET teams allows allegedly mentally disturbed individuals to be transported directly to a mental health facility after contact and examination by a PET team member. Otherwise, if police take an allegedly mentally disabled person into custody they must first take him or her to one of the community mental health centers, to jail, or to a special unit of the police department where a person designated by the county may, upon probable cause, make an application for emergency 72-hour treatment and evaluation pursuant to Section 5150 of LPS (the latter procedure typically occurs during off-hours when community mental health centers are closed); regular peace officers of the Los Angeles Police Department are not authorized to complete an application for emergency evaluation and treatment.

One deputy district attorney (and former police officer) viewed the procedure of peace officers taking mentally disturbed persons first to the mental health unit of the police department as an unnecssary, time-consuming, bureaucratic waste. He suggested that all police officers, not just specially designated officers, should have the authority to take mentally aberrant persons directly to a mental health facility for screening.

Once the PET team on "roll" with the police receives a referral for crisis intervention, the mobile unit (usually a community mental health technician and a police sergeant) proceed immediately to the caller's location or that of the allegedly mentally disordered person.

According to the mental health team we interviewed, the response time is usually a matter of minutes during the regular eight-hour shift when the PET team is on duty. Once the PET team has made contact with the allegedly mentally disordered person, they assess the person's mental condition and environment and determine whether there are sufficient grounds to believe that the person meets the LPS emergency treatment and evaluation criteria. Apparently, the PET team uses no standard assessment or mental health evaluation procedures. The team's approach seems to be dictated largely by the nature of the case, the behavior of the allegedly mentally disturbed person, the environment, and to a large extent, the intuition and common sense of the team members.

After an examination of the person's mental condition and environment, the PET mobile team can take several courses of action:

(1) Crisis intervention may be limited to an interview with the allegedly mentally disturbed person, aimed at overcoming what may be a temporary crisis and thereby preventing unnecessary and costly disruption of the person's life.

(2) If, in the opinion of the PET team, the person does not meet the LPS criteria, the PET team may simply try to persuade the person to voluntarily seek mental health care and may assist the person in taking advantage of such services.

(3) The person may be persuaded to accompany the PET team to the community mental health center and to pursue voluntary treatment on an outpatient or inpatient basis.

(4) If the PET team has probable cause to believe that the person is a fit subject for a 72-hour emergency "hold", the PET team may take the person into custody, complete an application for 72-hour detention, and cause the person to be transported to a mental health facility designated by the county and approved by the State Department of Mental Health.

The PET team members with whom we spoke estimated that approximately one-half of the crisis intervention cases resulted in applications for 72-hour emergency detention, treatment, and evaluation. The other half of the cases were screened and diverted by crisis intervention within one or more of the first three options, noted above, available to the PET team. One district attorney estimated that in all of Los Angeles County approximately 60 percent of the PET team crisis interventions resulted in a 72-hour emergency hold. Whatever the precise figure, PET teams screen and divert a significant proportion of the candidates for involuntary emergency hospitalization at the point of crisis intervention.

Interestingly, even when the PET team has found sufficient grounds for a 72-hour emergency hold, some individuals may still be diverted from involuntary hospitalization due to a shortage of hospital

beds. According to the PET team and several hospital administrators we interviewed, PET team members will typically call the mental health facility before completing an application for a 72-hour hold to reserve space for the allegedly mentally disordered person. If bed space cannot be reserved in the first facility contacted, the PET team will attempt to reserve space in another mental health facility. If bed space is hard to come by, however, they will not complete an application for emergency treatment and evaluation unless it is "essential." Reportedly, if the person meets the LPS criteria and satisfies this informally set criterion of seriousness, the team will proceed with an application for emergency care despite the nonavailability of hospital beds and "catch flak from the hospital later." In Metropolitan State Hospital, a certain number of beds are set aside to receive LPS commitments from each region of Los Angeles County. Apparently, the hospital may be full to capacity as defined by the arrangements made for a particular region yet have available space that is assigned to another region.

In sum, there are several opportunities for screening and diversion of allegedly mentally disordered persons from 72-hour involuntary emergency detention. Such screening and diversion is done by the PET team, first upon the initial telephone referral from a concerned relative, friend, or neighbor, and later as a result of direct contact with the allegedly mentally disordered person. It is based upon the team's assessment of legal criteria for involuntary detention, their common sense assessment of the person's mental condition and environment, and the availability of hospital space. Of course, some diversion of potential candidates for involuntary hospitalization may occur quite naturally without the intervention of PET team members or other mental health personnel. The absence of a practical alternative to initiating involuntary hospitalization by emergency action and the mere specter of PET team crisis intervention may cause many persons in Los Angeles to simply cope with the mental aberration of others or to seek help in some other way.

CUSTODY AND INVOLUNTARY DETENTION

In accordance with the least restrictive alternative concept, and in recognition that persons facing 72-hour holds are alleged to be mentally ill, in need of treatment, and importantly, have not committed criminal acts, every reasonable and appropriate effort should be made to take persons into custody in the most humane, least disruptive, and least conspicuous manner. While only implied in the LPS Act, such efforts are, to a certain extent, made in practice in Los Angeles.

According to law (5157), each person taken into custody for a 72-hour hold is to be given the following information by the authorized person taking him or her into custody:

(1) the name, professional designation (police officer, mental health professional), and agency affiliation of the person who takes the allegedly mentally ill individual into custody;

(2) that the custody-taking is not a criminal arrest;

(3) that the person is going to be taken for examination by mental health professionals at a specified mental health facility, identified by name;

(4) that legal rights will be explained by the staff of the mental health facility to which the person will be taken; and,

(5) if the person is taken into custody at his or her residence, that he or she may bring along a few personal items, make a telephone call, and leave a message for friends or family.

These statutory requirements for information to be given to the allegedly mentally ill person are noted on the form "Application for 72-Hour Detention for Evaluation and Treatment", which must be completed by the designated official who takes the allegedly mentally disordered person into custody.

Further, the process of court-ordered mental health evaluations initiated by a citizen's petition (5200 et seq.), a LPS provision not implemented in Los Angeles (as discussed earlier), is to be "carried out with the utmost consideration for the privacy and dignity of the person for whom a court-ordered evaluation is requested" (5200). Under the same provision, at the time a person is taken into custody for evaluation, the designated official taking the person into custody "shall take reasonable precautions to preserve and safeguard the personal property" of the person (5210), and whenever possible, the official "shall dress in plain clothes and travel in unmarked vehicles" (5212).

Mentally aberrant individuals coming to police attention when the regional PET team is not operating must be transported to the community mental health center functioning as the portal for 72-hour holds, to the police department's special psychology unit for initiation of emergency treatment and evaluation, or otherwise diverted by the regular police. Unfortunately, we did not acquire accurate estimates of the number of persons entering the mental health system by means of 72-hour holds initiated by the police without any assistance of or cooperation with a PET team, nor did we interview members of the special psychology unit of the police department in Los Angeles which receives candidates for emergency treatment and evaluation. We, thus, will restrict our discussion of emergency 72-hour holds (5150) to those in which PET teams are involved.

As discussed earlier, if the PET mobile unit (in the PET region where we interviewed each unit, called a "pair", consisted of a female community mental health technician and a male police sergeant) has reason to believe that the person observed and interviewed during crisis intervention is a fit subject for 72-hour emergency hold, they will take the person into custody, complete an application for emergency treatment and evaluation, and make appropriate arrangements to have the person transferred to a hospital. Our impressions, formed by interviews with members of the PET team, were that the PET teams take considerable pains

to take a person into custody in the most humane and least disruptive manner consistent with the perceived mental health treatment needs of the person. Reportedly, they always take into consideration the social context and environment in which they find the allegedly disturbed person. Descriptions of procedures and accounts of past cases by the members of the PET team whom we interviewed reflected a genuine concern and compassion for the mentally disordered people involved in the mental health-judicial system which, in our opinion, were unmatched by any other group of individuals we interviewed in Los Angeles.

Whenever possible, a relative, friend or acquaintance of the person, preferably the individual who contacted the PET team on behalf of the person, will meet the PET team at the place where the person is located, provide them with information, and render whatever assistance that may be necessary. The team may, on very rare occasions, and only when aided by the police, break down a door to gain access to a person in a life-threatening situation. According to PET team members, however, they typically find less drastic means to get to see the person.

Once the team has provided the crisis intervention warranted by the situation, and has determined that emergency treatment and evaluation seems the best course of action, they will advise the person of this as required by law (5157, see above), and make a telephone call to the local ambulance service to arrange transportation to a hospital. (Reportedly, most persons are transported to a hospital by ambulance when crisis intervention by the PET team results in a decision to apply for a 72-hour emergency hold.) The PET team customarily waits with the person until the ambulance arrives. If the community mental health technician feels that the person is likely to flee, she (the PET team members with whom we spoke were all women) will ask a family member or the police to remain with the person in one room while she completes the application for emergency action and calls the ambulance service from another location, such as another room of the house.

CONCLUSIONS AND RECOMMENDATIONS

Most commentaries on the LPS Act and its implementation begin the review of procedures under the Act with a description of the 72-hour emergency hold for screening and evaluation, perhaps with only a brief mention of those persons authorized to initiate such holds and of what criteria they are to apply. That is, the commentaries limit description of the beginnings of involuntary hospitalization in California to those procedures outlined in California mental health law (5150 *et seq.* and 5200 *et seq.*). These commentaries fail to draw notice to the prehospitalization procedures, discussed in this chapter, which dramatically affect the nature and frequency of involuntary commitments. Overstated, what occurs outside the hospital and courtroom is considered either unimportant or not malleable. Given what we would consider a major impact of prehospitalization procedures on the number and types of cases before Department 95, these procedures are not paid the attention they deserve.

The pre-hospitalization procedures and those persons that effect them (e.g., the petitioner or applicant for 72-hour emergency holds) are relatively invisible to the judge, public defenders, district attorneys, and mental health counselors. The gatekeepers to the involuntary hospitalization system, (police and members of the PET teams) rarely testify in court and make their views known to the judge. Insofar as the court's decisions concerning release related to the functioning of a person within the community at the time of custody-taking at least as much as they relate to a person's functioning within the mental health system once involuntary hospitalization has begun, the personnel of Department 95 should endeavor to make these pre-hospitalization procedures more visible and should accord them more weight.

For several reasons, the court should exercise some influence by reviewing, monitoring, and regulating prehospitalization procedures and events. First, these prehospitalization procedures and events directly bear on the number and types of cases that come before the court. In view of strained resources in the complex interorganizational civil commitment network in Los Angeles County, the court should influence policies and practices in the initiation process to promote screening and diversion of appropriate cases early in the process.

Traditionally, the commitment hearing has been considered the centerpiece in the involuntary civil commitment process. A second and related reason for the court to extend its influence into the prehearing period is that the early procedures and events may have more bearing on the equity, effectiveness, and efficiency of the commitment system than do any other parts of the commitment process. Several units of the mental health-judicial system in Los Angeles County are involved in initiation procedures: the gatekeepers or the police and PET teams, and the community portals or community mental health centers. Responsibility for a particular case may shift back and forth as the case proceeds toward disposition. The court is in the best position to effect cooperation among these various units, thereby maximizing fair and efficient practices.

Thirdly, if the court actively exerts influences in the early stages of the commitment process, it can ensure that individuals subject to a petition or application for commitment are afforded the applicable statutory and constitutional protections, thus protecting the individual's liberty interests.

A final and pervasive reason that the court in particular should assume this influential role is that the court is in the best position of authority to exercise this coordination function.

Initiating Involuntary Hospitalization

The ease with which involuntary civil commitment can be initiated will determine, to a large extent, the number and types of clientele who become involved in this process and, for whom the court must make decisions concerning release from involuntary hospitalization.

Not unlike the practice in other large cities (e.g., New York City and Chicago), Los Angeles County restricts access to the involuntary hospitalization system to one route, emergency treatment and evaluation, guarded by designated gatekeepers in the community. The gatekeepers for involuntary confinement for reasons of mental health in Los Angeles are specially designated peace officers and mental health personnel, exclusively. It is to these authorized individuals that others (i.e., citizens, relatives of the person, regular police) must turn to initiate 72-hour emergency holds for mental health treatment and evaluation. The route to involuntary hospitalization by means of a formal petition and subsequent court-ordered evaluation and treatment in non-emergency cases, as provided in LPS (5200 et seq.), is almost never used in Los Angeles County.

In our view, restricting entry into the involuntary civil commitment system to emergency cases making their way through community "portals" regulated by designated gatekeepers may have considerable merit. Such restrictions may be a matter of necessity in larger cities where the management of mental aberration and deviance is dictated less by mental health laws than by community tolerance of mental aberrations and community resources to deal with such deviance. It may be that, despite provisions in law for a relatively slow and deliberate process of involuntary hospitalization in non-emergency cases (e.g., Section 5200 et seq. of LPS), urban areas like Los Angeles can attend to only those emergency cases which literally force themselves upon the mental health-judicial system.

As discussed earlier in this chapter, LPS is viewed by some commentators as creating relatively easy access to short-term involuntary hospitalization. Our research in Los Angeles County did not support this view. Involuntary confinement is only pursued in emergency cases; others are referred or otherwise diverted to community resources. Authorized gatekeepers regulate entrance into the mental health system at designated portals in the community. The practice in Los Angeles County seems to severely restrict access to involuntary hospitalization and thereby safeguards against improper hospitalizations. While the restrictions on how emergency hospitalization may be initiated, and who may initiate it, do not necessarily prevent abuse, they make such abuse in Los Angeles County more difficult.

The restrictions on initiating involuntary civil commitment in Los Angeles cut two ways: at the same time that they make it quite difficult to effect the improper hospitalization of a person in Los Angeles, they make it quite a formidable task (some may say, unduly complicated and cumbersome) to get much needed involuntary treatment. Our major concern with the non-use of the non-emergency petition process and court-ordered evaluation in Los Angeles is that it might preclude access to involuntary treatment and evaluation, except in those cases where grave disability and dangerousness are directly observed by specially designated personnel. We feared the possibility that, in some

cases, mentally disordered persons in Los Angeles may be moving slowly towards starvation or self-inflicted violence behind closed doors, simply because informed relatives and friends cannot petition the court to intervene and police may be unwilling to break down doors to get to the mentally disordered person. We discovered that these fears were unfounded. The PET teams, when working at their best, will use common sense and intuition to provide crisis intervention whenever appropriate. It appears that the procedures of referral to community mental health centers and crisis intervention by regional PET teams have effectively replaced the petition and court-ordered evaluation process (5200) for short-term involuntary hospitalization.

Based upon our observations and interviews, we believe that the concept (we hesitate to call it a policy) of limited portals and gatekeepers in the community regulating involuntary hospitalization in Los Angeles is sound. Strained state and county resources, however, may make the concept difficult to implement. Derogatory references to the PET team crisis intervention as "emergency by appointment" may reflect a real slippage in implementation.

Two recommendations for court action and leadership in this area are offered. Both recommendations are aimed at making the pre-hospitalization procedures more visible to the court, and both recognize the court as the most influential unit within the interorganizational network involved in implementing the involuntary hospitalization process in Los Angeles--even in the pre-hospitalization stage, where the court may have direct contact with only a minority of those persons involved. (Here and elsewhere in this report, recommendations are discussed in the text preceding and following the recommendations.)

RECOMMENDATION: THE COURT SHOULD BECOME FAMILIAR WITH THE IDENTITIES AND THE METHODS OF OPERATION OF THE COMMUNITY PORTALS AND GATEKEEPERS FOR INVOLUNTARY COMMITMENT AT THE PRE-HOSPITALIZATION STAGE. FURTHER, THE COURT SHOULD USE ITS INFLUENCE TO FOSTER A UNIFORM POLICY OF IMPLEMENTATION FOR INITIATING EMERGENCY TREATMENT AND EVALUATION.

What happens when an individual in a certain part of Los Angeles County contacts a community mental health center seeking help with a friend or relative alleged to be dangerous or gravely disabled due to mental disorder? Is what happens similar to what might be expected in other parts of the county? At different times of the day? It is our opinion that the court (matters of strained court resources aside) should not only be able to answer these questions but also should take a leadership role in fostering a consistent policy for initiating involuntary civil commitment in Los Angeles County.

A forum for fostering familiarity with community portals and gatekeepers exists in the public sector of Los Angeles County. This forum is the Justice/Mental Health Committee (sponsored by the Program

Services Bureau of the Los Angeles County Mental Health Department). Participants in this forum include officers of the court, the District Attorney's Office, and the Public Defender's Office, and mental health counselors and Department of Mental Health personnel. The goals of the immediately preceeding and following recommendations would be furthered if gatekeepers and representatives of community portals were included in this forum.

The Department of Mental Health in Los Angeles County has made strides toward the fostering of a uniform implementation policy for the initiation of emergency treatment and evaluation. One Department of Mental Health source has indicated that the Department's understanding of proper implementation policy begins in statute. Section 5150 states that upon probable cause, peace officers, or other persons designated by the county, may take or cause to be taken into custody any person who, as a result of mental disorder, is a danger to others or to him or herself, or is gravely disabled, and may place him or her in a facility designated for 72-hour evaluation and treatment. The Department feels that law enforcement personnel should use their own standards in determining whether an individual appears to need mental health services. After a person has been taken into custody and transported to a mental health facility, mental health professionals can make the appropriate disposition under the statutory criteria. It is the policy of the Department of Mental Health that persons whom law enforcement personnel deem to suffer from a mental disorder be transported to the nearest county mental health facility for evaluation and appropriate disposition. To facilitate a clear understanding of this policy the Department has communicated to law enforcement the location and hours of operation of all of the Department's mental health facilities. The Department's efforts are commendable. The above recommendation encourages the court, because of its influential position in the civil commitment network, to participate in the promulgation and uniform implementation of such policies.

The court must make daily decisions concerning release from involuntary hospitalization not only in the context of ever-changing legal requirements (see Chapter IV), but also in the context of resource allocations of the various units in the mental health-judicial system. The ebb and flow of the community portal and gatekeeper resources greatly influence the work of the court. A familiarity with the operation and an involvement with policy implementation in the pre-hospitalization stage of the involuntary civil commitment process would well serve the court and the community.

Are some gatekeepers in Los Angeles County more lenient in allowing entry through the portals as a "safety valve" for family disputes? Could a consistent policy for initiating involuntary confinement in Los Angeles influence the numbers of persons involuntarily hospitalized as compared to those diverted from involuntary hospitalization? In our opinion, these questions are worth answering. The most capable and influential unit of the involuntary hospitalization network in Los Angeles, which is in a position to address these questions effectively, is the Superior Court, Department 95.

The second recommendation suggests a method by which the court may become familiar with the pre-hospitalization procedures in initiating involuntary confinement. It grew out of a discussion with members of one PET team about the relative invisibility (to the court) of the pre-hospitalization procedures.

RECOMMENDATION: COURT PERSONNEL (THE JUDGE, DISTRICT ATTORNEYS, PUBLIC DEFENDERS, AND MENTAL HEALTH COUNSELORS) SHOULD OCCASIONALLY MEET WITH THOSE PERSONNEL SPECIALLY DESIGNATED TO TAKE ALLEGEDLY MENTALLY DISTURBED PERSONS INTO CUSTODY FOR EMERGENCY TREATMENT AND EVALUATION. IDEALLY, THE PROCEDURES FOR CUSTODY-TAKING AND CRISIS INTERVENTION SHOULD BE PERIODICALLY OBSERVED BY COURT PERSONNEL.

The non-use of the petition process and court-ordered evaluation has isolated the court from the petitioners or applicants for involuntary commitment in Los Angeles. Reportedly, it is a rare occurrence when a member of a PET team or a peace officer testifies during a writ hearing. As a result, the court has little information about the circumstances of involuntary detainment beyond the scant information provided on the original application for 72-hour detention for evaluation and treatment, and whatever information may be volunteered by the detained person. The knowledge and understanding that comes from direct observation (including hearing, seeing, and feeling) may place the procedures and decisions in the courtroom in a more meaningful context. One PET team member suggested, with some encouragement from us, that every "new" judge spend several hours with a mobile PET team in a cruiser as part of his or her orientation.

Screening and Diversion from Involuntary Hospitalization

A number of factors and procedures operate to screen and divert persons in Los Angeles County from involuntary detainment and hospitalization, thereby, arguably, protecting their liberty interests. Only specially authorized officials can evaluate and decide to detain allegedly mentally disordered persons for evaluation and treatment. Entry into the involuntary civil commitment system is funneled through community mental health centers. A shortage of beds in Los Angeles County effectively blocks all but the most serious cases from involuntary hospitalization. Finally, a significant proportion of the potential candidates for involuntary hospitalization are screened and diverted to outreach programs or other community services by PET teams and other gatekeepers.

There is obviously less curtailment of liberty for most of those individuals successfully diverted from involuntary detainment. The screening procedures and other factors serving to block the route to involuntary hospitalization, when successful in diverting mentally disturbed individuals from the involuntary civil commitment system to some other appropriate form of help, embody the best intents of law and mental health practice by providing treatment in the least restrictive

environment that is less disruptive of family, social, and economic ties. Screening mechanisms also seem to be extremely beneficial for cost-containment. In the absence of screening and diversion (assuming even very conservative estimates of the number of people diverted from involuntary hospitalization), it is likely that hospital and judicial costs would soar.

The following recommendations are aimed at increased coordination between the court and the community portals and gatekeepers in the screening and division of potential candidates for involuntary hospitalization to other resources in the community. Effective community mental health-judiciary coordination are far from commonplace throughout the country. Where they do exist (e.g., Columbus, Ohio), they have been of service in balancing the liberty interests of those individuals facing involuntary confinement, the treatment needs of those individuals suffering from mental disorders causing them to be gravely disabled or dangerous, the interests of the state in helping the needy and protecting itself from the dangerous, and in conserving fiscal resources.

RECOMMENDATION: GATEKEEPERS (PET TEAM MEMBERS, DESIGNATED PUBLIC AND PRIVATE MENTAL HEALTH PERSONNEL, AND DESIGNATED LAW ENFORCEMENT OFFICIALS) SHOULD BE ENCOURAGED TO OUTLINE AND COMMUNICATE TO THE COURT THE POLICIES, PROCEDURES, CRITERIA, AND OPERATIVE STANDARDS FOR SCREENING AND EVALUATION IN CRISIS INTERVENTION WITH ALLEGEDLY MENTALLY DISTURBED PERSONS IN LOS ANGELES COUNTY.

RECOMMENDATION: THE COURT, IN THE ROLE OF A REGULATORY OR ADMINISTRATIVE UNIT OF THE MENTAL HEALTH-JUDICIAL SYSTEM, SHOULD REVIEW THE PREHOSPITALIZATION SCREENING AND EVALUATION POLICIES AND PROCEDURES IN LOS ANGELES COUNTY, AND FOSTER THE ADOPTION OF A SOUND AND CONSISTENT SET OF POLICIES AND PROCEDURES. THE COURT SHOULD ASSUME A LEADERSHIP ROLE IN REVIEWING REPRESENTATIVE SAMPLES OF APPLICATIONS FOR 72-HOUR DETENTION FOR EVALUATION AND TREATMENT, AND SHOULD ADVISE AUTHORIZED APPLICANTS ABOUT RECOMMENDED INFORMATION TO BE CONVEYED IN SUCH APPLICATIONS.

To repeat, though not without problems in implementation, the above recommendations have implications for striking a balance between the liberty interests of those persons facing involuntary detainment and the treatment needs of mentally ill or dangerous persons. Further, the recommendations have implications for cost-savings achieved by the adoption of a policy diverting the maximum number of persons from expensive hospitalization, and for ultimately providing the Court with more complete information concerning the mental status of persons at the time of custody-taking and involuntary detainment.

Custody and Involuntary Detainment

The custody-taking and involuntary detainment of allegedly mentally disordered persons by mobile PET teams in Los Angeles are praiseworthy. The effect of a police uniform and the use of a police cruiser in taking custody of mentally disturbed individuals are not clearly defined nor understood very well in Los Angeles, or elsewhere for that matter. On the one hand, the perceived authority associated with the police uniform and the marked cruiser may facilitate taking a violent person into custody. On the other hand, the same uniform and marked police cruiser may be a conspicuous symbol of a physical and psychological disruption in the life of a mentally disturbed person. A PET team, especially a mobile pair consisting of a mental health worker and a peace officer, seems to strike a good balance, especially when involuntary hospitalization is viewed by the community as only one possible consequence of crisis intervention by the team. The procedure in Los Angeles of transporting persons alleged to be fit subjects for involuntary commitment to the hospital by means of ambulance is unique. Just as handcuffs and a police cruiser may be symbols of criminal arrest, an ambulance may appropriately signify mental health or medical intervention.

Los Angeles County is divided into five geographic mental health regions for administrative and service delivery purposes. At this writing, only one of these regions has a 24-hour mobile psychiatric emergency response system which works in conjunction with law enforcement. Reportedly, the other four regions will be phasing in their 24-hour mobile response systems as resources become available. Because each of these regions is unique as to demography, topography, relative needs, and mental health resources the response system may vary among the regions.

RECOMMENDATION: THE COURT SHOULD USE ITS INFLUENCE TO ENCOURAGE THE DEVELOPMENT, THROUGHOUT LOS ANGELES COUNTY, OF MOBILE PSYCHIATARIC EVALUATION TEAMS (PET) CAPABLE OF RAPID-RESPONSE CRISIS INTERVENTION ON A 24-HOUR BASIS, AND CUSTODY-TAKING AND INVOLUNTARY DETAINMENT BY MEANS OF A MOBILE POLICE OFFICER-COMMUNITY MENTAL HEALTH TECHNICIAN TEAM WHEN APPROPRIATE.

RECOMMENDATION: BECAUSE THE NON-EMERGENCY PROCEDURES PROVIDED IN SECTION 5200 ET SEQ. ARE GENERALLY NOT USED IN LOS ANGELES COUNTY, AND BECAUSE THIS SECTION PRESCRIBES SAFEGUARDS FOR RESPONDENTS DURING THE PRE-HOSPITALIZATION STAGE OF INVOLUNTARY CONFINEMENT (E.G., CONSIDERATION OF PRIVACY AND DIGNITY, RIGHT TO BE ACCOMPANIED TO PLACE OF EVALUATION BY RELATIVE, PRECAUTIONS TO SAFEGUARD PERSONAL PROPERTY), THE COURT SHOULD ENSURE THAT THE APPLICABLE SAFEGUARDS OF THIS SECTION ARE PART OF THE CURRENT PRE-HOSPITALIZATION PRACTICES.

The next chapter focuses upon those procedures and events occurring in Los Angeles County once an allegedly mentally disordered person has been taken into custody against his or her will and transported to a designated mental health facility for 72-hour emergency evaluation and treatment.

CHAPTER III

EMERGENCY 72-HOUR HOSPITALIZATION FOR EVALUATION AND TREATMENT

In the last chapter, we considered the legal requirements, procedures, and events in the involuntary civil commitment process in Los Angeles occurring before a person is actually detained involuntarily in a mental health facility. This chapter focuses on the initial 72-hour involuntary detention period in an approved facility after the person thought to be dangerous or gravely disabled as result of mental disorder has been apprehended, taken into custody, and transported to the facility.

Although judicial review is often seen as the focal point of the involuntary civil commitment process, what occurs before court intervention may have a much greater bearing on the life of the involuntarily hospitalized individual and, from a broader perspective, the community. The initial 72-hour emergency holding period provided in LPS is unique among the various stages of commitment articulated in the Act insofar as no provision is made for judicial review, ex parte or otherwise, nor for the appointment of counsel (cf. Chapter IV). As discussed in the previous chapter, prompt and reliable decisionmaking in screening and diverting persons from compulsory hospitalization in the early stages of the commitment process, protects the person's liberty interests, the interest of the person and mental health providers in good treatment in the least restrictive setting, and the taxpayer's pocketbook.

The mental health facility to which an allegedly mentally disturbed person is taken need not necessarily admit that person. If, in the judgment of the staff of the facility, the person can be better served without being involuntarily detained, he or she "shall be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis" (5151). If the person is admitted to the facility, he or she may be detained for evaluation and treatment for 72 hours. Saturdays, Sundays, and holidays may not be counted in this 72-hour period for certain mental health facilities, subject to the certification and periodic review of the Department of Mental Health (5151). While the nature of the mental health evaluation to be provided during this initial holding period is not specifically defined in LPS, the evaluation may, generally, consist of

> [m]ultidisciplinary professional analyses of a person's medical, psychological, social, financial, and legal conditions as may appear to constitute a problem. Persons providing evaluation services shall be properly qualified professionals and may be full-time employees of an agency providing evaluation services or may be part-time employees or may be employed on a contractual basis. (5008)

Similarly, the treatment to be provided during this period is not specifically defined. Once a person is admitted, LPS mandates that the person "shall receive an evaluation as soon after he is admitted as possible and shall receive such treatment and care as his condition requires for the full period that he is held" (5152). A person may be released from the mental hospital before 72 hours have elapsed if, in the opinion of the attending staff, the person no longer "requires evaluation or treatment" (5152).

In this chapter, we will discuss, in turn, the practice of screening and evaluation of allegedly mentally disturbed individuals pursuant to and after actual admittance to a hospital, emergency treatment, and finally, the opportunities for outright release from the hospital and diversion from the involuntary 72-hour detainment provided in LPS.

MENTAL HEALTH SCREENING AND EVALUATION IN THE HOSPITAL

An individual alleged to be mentally disordered is screened and evaluated, both formally and informally, against the LPS commitment criteria (i.e., mental disorder, dangerousness, or grave disability) at several different points in the involuntary commitment process in Los Angeles County. As discussed in the last chapter, the first opportunity occurs during the initial contact with a regional mental health facility in Los Angeles County. The second opportunity usually occurs when a designated gatekeeper (peace officer, PET team member, or mental health professional) assesses whether sufficient grounds exist to trigger involuntary detention and 72-hour emergency treatment and evaluation. The next opportunity to test the appropriateness of involuntary hospitalization occurs at the time of admission to an authorized mental health facility for 72-hour treatment and evaluation.

Before a person can be considered for admission to a facility for emergency treatment and evaluation, the receiving facility must have an application, completed by the person who effected the original detention, stating the circumstances under which he or she believes there is probable cause to believe that the person is a danger to others, to himself, or gravely disabled as a result of a mental disorder (5150). Presumably, if a person arrives at the door of a mental health facility without a completed application by an authorized applicant, the attending staff must either complete an application for an emergency hold before formally admitting the person, or simply refuse to admit the person on an involuntary basis. Metropolitan State Hospital, the only state hospital in Los Angeles County, has a policy of not completing applications for 72-hour emergency holds except in "extenuating circumstances," preferring instead to receive involuntary patients from regional community portals with already completed applications (Metropolitan State Hospital, Forensic Department, unpublished document, no date). Apparently, a voluntary patient already at the hospital who meets the LPS criteria and who the hospital may want to retain involuntarly represents an exception to this policy, that is, an "extenuating circumstance."

At another major intake point for the inpatient mental health system in Los Angeles County, Olive View Mental Health Center, the required applications for emergency holds often may be filled out by a member of the attending staff, even when an application has already been previously completed by the police, for example. According to one Olive View staff member, this may be done in situations where the information contained in the first application is incomplete. In such cases, however, both applications become part of the hospital record.

Persons transported to a hospital for involuntary emergency treatment and evaluation typically are taken to a section of the admissions area where: (1) the papers required by law and hospital policies are completed; (2) the person is advised of his or her rights, and informed of the bases, nature, and likely consequences of the 72-hour emergency hold; and (3) the attending hospital staff screen and evaluate the person's physical and mental condition. Typically, a person is evaluated three times during a 72-hour hold. The purpose of the initial evaluation is to confirm the allegations in the application that the person is a fit subject for involuntary commitment and to determine whether admission to the hospital will be granted. This evaluation, or screening, is typically conducted by a physician and a psychologist, social worker, or psychiatric nurse. If the evaluation reveals a physical problem, the person may not be admitted. To be admitted on a 72-hour hold to Metropolitan State Hospital, an acute psychiatric facility, for example, a person must be "medically clear" of physical symptoms; otherwise, the person is referred to another hospital.

At Olive View Mental Health Center, a general community hospital, a person with apparent medical problems may be similarly refused admission for emergency mental health treatment and evaluation, but may receive medical treatment at Olive View on a voluntary basis. The assessement of the persons mental condition is typically cursory, and usually consists of a brief mental status examination (i.e., examination of such observable characteristics as the persons general appearance, speech, mood or affect, orientation in time and place, available social and family history, and unusual behaviors) and a determination of whether the person is a fit subject for involuntary confinement.

Our observations and discussions with mental health personnel in Los Angeles County gave no indication that this initial mental health screening, at the time of hospital admission, involved any close tracking of legal commitment criteria. For example, in assessments of grave disability it appeared that examiners, at least in the initial evaluation of the respondent, seldom conducted thorough investigations concerning whether the respondent indeed had food, clothing, or shelter. Instead, as is true generally throughout the country, the initial mental health screening of the respondent upon his or her entry into the mental health-judicial system is based less on strictly defined legal or mental health standards than on commonsensical determinations involving the personal, moral, ethical, social, and professional judgments of the mental heath examiners.

Once the initial mental health and medical screening is complete, and the person has been admitted to the facility for a 72-hour emergency hold, the person is sent from the admission area to a ward in the hospital for emergency treatment and another evaluation. The time that elapses between admission to the hospital and transfer to a unit or ward for treatment varies from facility to facility. At Olive View Mental Health Center, according to one member of the attending staff, a person usually is sent to a treatment unit within ten hours of admission. On occasions when Olive View Mental Health Center and other facilities to which a person may be transferred are filled to capacity, described one Olive View staff member, a person admitted on a 72-hour hold will be kept in an "emergency holding room" for up to 72 hours, a procedure called "guesting." At Metropolitan State Hospital, patients admitted during morning hours are typically attended to by a "ward team" the afternoon of the same day; if they are admitted after noon, they may not be attended to by the treatment team until the following morning.

The second mental health evaluation during the 72-hour hold, a series of assessments performed by different members of a professional team, is performed more thoroughly and intensely than the initial mental health screening upon hospital admission. It is our impression that this evaluation is conducted in Los Angeles County primarily to determine the proper course of treatment, although nothing precludes members of the treatment team from evaluating the person's mental state against the LPS criteria at this stage. That is, if the hospital treatment team believes that the person is no longer a fit subject for involuntary confinement as defined by LPS, they may discharge the person from the hospital at any time. The options of release, continued commitment, or some other treatment alternative, however, are typically reviewed during yet a third, and final evaluation at the end of a 72-hour hold to determine if an additional 14-day commitment (5250; see Chapter V) is justified.

During the 72-hour hold, members of the attending staff may make efforts to exchange information about the respondent with members of the person's family or other individuals identified by the person. This exchange of information is for the purposes of evaluating the mental health, medical, and social history of the person, as well as informing concerned members of the family as to the presence and condition of the person. One mental health official said that this exchange of information is seriously impeded by the statutory mandate (5328.1) requiring the person's permission, which may be withheld by a refusal or incapacity.

EMERGENCY TREATMENT

Strong conflicting interests surround the issue of treatment before judicial review of involuntary hospitalization. On the one hand, during the early periods of involuntary hospitalization it will not yet have been determined by judicial review that the criteria for involuntary detainment have indeed been met, and the person may, in fact, have been wrongfully detained. On the other hand, a person's obviously deteriorating mental condition and aberrant behavior may seriously threaten not only his or her own safety, but that of those around him or

her. Further, practical considerations of ecomony, efficiency, and convenience may also be crucial in the attempt to balance these conflicting interests.

Except for especially intrusive treatments (e.g., psychosurgery and convulsive treatments), LPS does not address the issue of the nature and type of treatment to be provided during a 72-hour emergency hold. In general, a person "shall receive such treatment and care as his condition requires" (5152). In practice, the issue of the treatment of an involuntarily detained person before judicial affirmation of involuntary commitment, a delicate matter in other parts of the country, engenders relatively little controversy in Los Angeles County.

Typically, a hospital treatment team will evaluate a person on 72-hour emergency hold and, based on the results of that evaluation, immediately begin treatment and discharge planning. The treatment team, or "ward team," assigned to persons on 72-hour holds in Metropolitan State Hospital, consists of a "treating" physician, a psychiatric nurse, a psychologist, and a social worker. At Olive View Mental Health Center, the treatment team consists of a physician (usually, the same psychiatrist who initially evaluated the person upon admission), a psychiatric social worker, a case worker assigned primarily to discharge planning, and a mental health counselor (a member of the hospital nursing staff) assigned to the duties of advising the person of his or her legal rights and requirements. As far as we could ascertain, except for a possible delay caused by the hospitals' efforts to meet legal requirements, persons involuntarily detained on 72-hour holds are treated the same as voluntary hospital patients.

RELEASE AND DIVERSION FROM INVOLUNTARY HOSPITALIZATION

As indicated earlier, a hospital has broad powers to release involuntarily detained persons. If at any time during a 72-hour hold a person "no longer requires evaluation or treatment" (5152) and, presumably, the person is no longer thought to be a danger to others, a danger to him or herself, or gravely disabled, he or she may be discharged from the hospital. Further, if in the judgment of the hospital attending staff, a person's treatment needs are better served by an alternative to involuntary commitment, the person may be released and provided other mental health services on a voluntary basis (5151). In practice, a significant proportion of the persons held for emergency treatment and evaluation are released by the hospital or converted to voluntary status before the end of the initial 72-hour period of involuntary hospitalization. For example, during April, May, and June, 1980, in Los Angeles, a total of 5,017 persons were involuntarily detained for 72-hour evaluation and treatment; of that total, 3,524 persons were detained further for an additional 14 days of intensive treatment (Data Matters, State of California, January 29, 1981). Thus, one out of three persons involuntarily detained is either released or converted to voluntary hospitalization status within 72 hours.

The members of one PET team with whom we spoke complained that many persons for whom they effected the initial involuntary detention are

able to "get it together" for a short period of time during hospital admission, and are consequently released from the hospital after a very short period of time. Their complaint was not that these persons were improperly released but that they were discharged into the community, often with symptoms of mental disorder, without effective referral to, or notification of, the local mental health center or portal through which they initially passed. They suggested that these discharged patients (as well as those involuntarily detained persons who may have filed a writ of habeas corpus but are released due to the fact that the district attorney has chosen not to pursue the case; see Chapters V and VII) should be referred to the community mental health centers for voluntary mental health services.

CONCLUSIONS AND RECOMMENDATIONS

Perhaps due to the sheer number of factors potentially serving as checks and balances--mental health screening and evaluation, opportunities for release and diversion from involuntary detainment, and mental health intervention in the form of treatment and discharge planning--to be met during the relatively short 72-hour initial involuntary detention period, involuntarily detained persons in California, relatively speaking, may be better off (in terms of liberty and treatment) than their counterparts in other states during the initial period of involuntary hospitalization. Although many states provide judicial review and appointment of counsel much earlier in the process than provided for in LPS, only a few jurisdictions throughout the country (e.g., Ohio and Connecticut) make such provisions within three days of involuntary hospitalization. Thus, without considerations of quality and validity of the procedures and events, the sheer number of mental health screenings, evaluations, and opportunities to assess the person's condition against the LPS criteria during the initial 72-hour period of confinement are meritorous aspects of the involuntary civil commitment process in Los Angeles County.

Certainly, even though no statutory provision is made for judicial review or appointment of counsel during this initial period of involuntary detention, the practice in Los Angeles County seems to comport with the legislative intent of LPS to provide prompt evaluation and treatment (5001). The ultimate judgment concerning whether the informal screenings performed by county-designated gatekeepers, together with the mental health screenings and evaluations described in this chapter, can effectively protect the liberty interests of persons involuntarily detained for 72-hour holds may be less a matter of fact and logic than it is a matter of values that needs definition by legislative directive (see Chapter IV).

Speaking generally (and having already stated that the 72-hold in the Los Angeles process is worthy of some praise) we conclude from our study of the legal requirements, procedures, and events occurring during the 72-hour emergency hospitalization for evaluation and treatment that the court fails to take sufficient notice of the occurrences during this initial period of confinement, just as it fails to take adequate notice of the pre-hospitalization stage of involuntary civil commitment (see

Chapter II). In the remaining parts of this chapter we discuss our general recommendation that the Court should significantly expand its purview of the involuntary hospitalization process to include the initial involuntary detention period provided by LPS.

Mental Health Screening and Evaluation in the Hospital

Taken as a whole, as well as together with the checks and screenings by the gatekeepers during the pre-hospitalization stage, the mental health screenings and evaluations provided to the person on 72-hour hold (at the time of admission, approximately midway through the initial detention period for the purpose of the development of treatment plans, and, finally, at the end of the period to determine the necessity for continued hospitalization) are strengths in the Los Angeles County system. The admission screening is performed at the ~~the~~ very early stages of the involuntary civil commitment process and provides opportunities for diversion from compulsory hospitalization. The protection that these screenings and evaluations provide against improper involuntary hospitalization, at least in theory, is substantial. The legislative intent, at least that expressed in statute (5001), appears to be adequately complied with in practice.

The results of the mental health examinations and screenings, however, may be underutilized by the Court. Further, the screenings and evaluations performed by mental health personnel during the 72-hour holds may benefit from a closer tracking of the language of the LPS criteria. Assuming that the testing of the justifications for involuntary hospitalization performed by law enforcement and mental health personnel during the pre-hospitalization stage and the 72-hour hold are valid, economy and efficiency seem to dictate that the Court make full use of this testing during judicial review. (As in the previous chapter, recommendations for improvements are interspersed in the text, preceding or following supporting commentary.)

RECOMMENDATION: THE COURT SHOULD MAKE MUCH GREATER USE OF THE INFORMATION THAT IS ACQUIRED IN THE MENTAL HEALTH EXAMINATIONS OF PERSONS INVOLUNTARILY DETAINED FOR 72-HOUR EMERGENCY EVALUATION AND TREATMENT.

RECOMMENDATION: ALONG WITH THE NOTICE OF CERTIFICATION FOR AN ADDITIONAL 14 DAYS OF INTENSIVE TREATMENT, THE COURT SHOULD ALSO RECEIVE INFORMATION ABOUT THE CONDUCT AND OUTCOMES OF ALL SCREENINGS AND MENTAL HEALTH EXAMINATIONS PERFORMED DURING THE 72-HOUR DETENTION, INCLUDING THE ADMISSION SCREENING, EXAMINATIONS PERFORMED BY THE HOSPITAL TREATMENT TEAM DURING THE 72-HOUR PERIOD, AND THE EVALUATION RESULTING IN THE CERTIFICATION FOR 14-DAY INTENSIVE TREATMENT.

If the person contests the certification decision and requests habeas corpus relief (see Chapters V and VII), the Court should have

sufficient data to test the allegations supporting the certification. Given the limited time that public defenders have for conferences with the testifying mental health personnel (often this is not the treating physician) before writ of habeas corpus hearings, and given the often brief testimony, a written record before the Court tracing the history of mental health reviews of the person's condition before the hearing may not only facilitate judicial review but may also cause a closer tracking of LPS criteria by examiners. Also, this information should provide evidence that a careful mental examination has been conducted and should provide the factual basis for diagnosis, prognosis, and the justifications for further intensive treatment.

Moreover, reports of the admissions screenings, especially, contain valuable information about the person and his or her environment typically unavailable from other sources. The admissions screener has the opportunity to examine the person close to the time and circumstances under which a county-designated gatekeeper effected the original involuntary confinement. Early examinations provide the opportunity to observe and interview the person at the time, or close to the time, that the allegations pursuant to involuntary hospitalization were made, when the person may yet be uninfluenced by the process of "institutionalization."

RECOMMENDATION: THE COURT SHOULD URGE EXAMINERS TO TAKE TIME AND CARE TO EXPLAIN TO EACH PERSON EXAMINED THE NATURE AND PURPOSE OF THE EXAMINATION, ITS PLACE IN THE INVOLUNTARY HOSPITALIZATION PROCESS, AND THE LIKELY CONSEQUENCES OF THE EXAMINATION.

LPS does not provide a person the right to remain silent during mental health examinations, nor does it require that examiners disclose the purpose, nature, and consequences of the examination process. In our opinion, whenever permitted by the patient's mental condition, a full and open disclosure of the purpose, nature, and consequences of the examination in the context of the involuntary hospitalization process is dictated by the ethical codes of psychiatrists, psychologists, and social workers alike, regardless of the requirements of law. In fairness, persons should be satisfied in their desire to know what is happening to them and why. In our experiences in other jurisdictions, few examiners, regardless of their attitudes, report that few persons refuse to talk to them as a matter of a legal right, although many refuse because they are either too hostile or too sick to communicate.

Of course, few examiners like to begin their interactions with mentally disturbed individuals by "reading their rights" to them. Perhaps imagining a scene in which a criminal defendent is given Miranda warnings by police while being forced against a wall with arms and legs extended, most examiners will feel that this instantly destroys any chance for a candid exchange in an atmosphere of trust and support. On the other hand, many examiners who always make a frank disclosure and explanation report that the patients are pleased that an examiner levels

with them. The result is an enhanced atmosphere of trust and cooperation. Ironically, the effects of an open, honest explanation, using the best skills acquired by the helping professions, are usually not the negative ones that might be expected. Rather than causing the person to be cautious about his or her responses to the examiner, they frequently remove resistances and the person speaks openly.

Emergency Treatment

The treatment of persons who are involuntarily hospitalized, especially those persons that have requested release and are awaiting judicial review of their confinement, is an issue that raises little controversy in Los Angeles County. In practice, most persons are medicated and provided other types of therapies shortly after they are admitted to the hospital. Except for their legal status, and perhaps some of the hospital staff members' trepidations about that status and related liability threats, persons involuntarily hospitalized on 72-hour holds are treated essentially the same as any voluntary patient in the hospital, all other things being equal. We consider this equity commendable.

Nonetheless, whether or not a person is medicated may have other legal, as well as therapeutic, relevance. A person who is properly medicated will often present a better appearance before the Court during judicial hearings. On the other hand, medication, especially over-medication, may bias a case contesting prolonged involuntary hospitalization. Medication may cloud a person's thinking and diminish his or her ability to assist counsel. Some medication, even when properly prescribed and administered, may give a person the appearance of being mentally disturbed, which, of course, would work against him or her during a writ hearing.

RECOMMENDATION: UPON FIRST MEETING WITH CLIENTS, PUBLIC DEFENDERS SHOULD FAMILIARIZE THEMSELVES WITH THE TYPE OF TREATMENT GIVEN TO THEIR CLIENTS, ESPECIALLY WHEN THE TREATMENT CONSISTS OF MEDICATION THAT IS LIKELY TO AFFECT THE PERSON'S DEMEANOR DURING COURT HEARINGS.

Release and Diversion from Involuntary Hospitalization

The broad powers to release or convert a person to voluntary hospitalization status, in effect at any time during the 72-hour hold, is clearly a positive aspect in the Los Angeles County involuntary civil commitment system. These powers serve to safeguard against improper hospitalization. As the legal and mental health communities become less concerned with improper compulsory hospitalization and more concerned with the premature release from the hospital of persons still "warm with symptoms," the discharge and release policies of mental health facilities may have to withstand closer public scrutiny. Resource allocation, administrative burdens, and fiscal concerns may become paramount, if they are not already so, in Los Angeles County.

RECOMMENDATION: THE COURT SHOULD ENCOURAGE HOSPITAL FACILITIES TO COMMUNICATE THEIR DISCHARGE POLICIES FOR INVOLUNTARILY DETAINED PERSONS TO THE COURT, AS WELL AS TO THOSE AGENCIES EMPLOYING OFFICIALS DESIGNATED TO EFFECT INVOLUNTARY HOSPITALIZATION.

With this recommendation we do not envision the development and preparation of a formal set of policy and procedural guidelines. Instead, we suggest the writing of memoranda by the hospital facilities that would inform and assist the Court to understand the practice of the mental health facilities in discharging respondents previously detained involuntarily. This understanding may lead to more informed and facilitated decisionmaking. Courts make decisions regarding release within a context much larger than that encompassed by the courtroom and the precise time of the writ hearing. Decisions are influenced by their consequences and the more informed about those consequences those decisions are, the better those decisions may be.

The last recommendation in this chapter addresses a related issue. Although release from involuntary hospitalization clearly serves the liberty interests of a person, the needs for some type of mental health treatment for those released persons whose condition no longer meets LPS criteria for involuntary hospitalization yet warrants further treatment, are only served by their referral to community services upon discharge. As indicated in this chapter, the linkage to continued mental health services in the community for persons released from the hospital following involuntary detainment appears to be lacking.

RECOMMENDATION: THE COURT SHOULD USE ITS INFLUENCE TO ENCOURAGE HOSPITALS TO REFER DISCHARGED PERSONS TO THE COMMUNITY MENTAL HEALTH FACILITY WHICH EFFECTED THE ORIGINAL INVOLUNTARY DETAINMENT.

In the next chapter we will discuss the policies and procedures devised by the mental health system in Los Angeles County to conform to the recent Ninth Circuit decision affirming the District Court's ruling that "due process requires a probable cause hearing after the 72-hour emergency detention period for persons alleged to be gravely disabled" (Doe v. Gallinot, 657 F.2d 1017 [1981]). As will be discussed, the Gallinot decision has engendered considerable controversy but, as yet, no uniformity of procedures for probable cause hearings throughout Los Angeles County. Then, continuing with our chronological review of the commitment process in Los Angeles, in Chapter V we will discuss the legal requirements, procedures, and events occurring during a 14-day involuntary hospitalization period subsequent to the initial 72-hour detention discussed in this chapter.

CHAPTER IV

PROBABLE CAUSE (GALLINOT) HEARINGS

Judicial and mental health officials involved in decisions concerning release of involuntarily detained persons must contend with an ever-changing set of legal requirements. Moreover, the requirements may be unclear, causing confusion and making compliance difficult, if not impossible. The latest perturbation for court and mental health personnel in Los Angeles County has been caused by the decision in the case of Doe v. Gallinot (657 F.2d 1017 (1981)). Our purpose in this chapter is not to review this case in the context of statutory and case law, but to examine its impact on past, present, and future practice in Los Angeles County. We begin with a brief look at the Gallinot case itself, limiting ourselves to those aspects of the case that we believe have particular relevance to the conduct of probable cause hearings in Los Angeles County.

THE CASE OF DOE v. GALLINOT

Seven years ago, on February 27, 1975, John Doe, the plaintiff, was observed and apprehended in a hospital parking lot by Santa Monica Police Officer Gary Gallinot, who subsequently transported Doe to a designated county mental health facility where he was examined by a psychiatric nurse, Velma Tamanaha. Ms. Tamanaha, an authorized gatekeeper, concluded that Doe was gravely disabled, and completed an application for a 72-hour emergency hold for treatment and evaluation at Camarillo State Hospital. On Ms. Tamanaha's application, Doe was transported by ambulance and committed to Camarillo where he was administered sedatives and psychotropic (anti-psychotic) medications, including large doses of Thorazine, Stelazine, and Haldol. On March 4, 1975, a Camarillo staff physician certified that Doe continued to be gravely disabled requiring an additional 14 days of treatment pursuant to Section 5250 of LPS (see next chapter).

Doe appeared in the Superior Court of Ventura County on March 7 and 11, 1975, pursuant to his request for judicial review by habeas corpus of his continued commitment. On March 11, his writ was granted and he was released from Camarillo the next day, a full 14 days after his initial contact with Officer Gallinot in Santa Monica.

Although Doe was eventually afforded habeas corpus review of his involuntary detainment in Camarillo and was subsequently released, he filed suit in April 1977 in the U.S. District Court, Central District of California, for declaratory, injunctive, and monetary relief. He claimed that LPS was unconstitutional because it deprived him of due process, which required a mandatory review of his involuntary commitment to Camarillo State Hospital beyond a 72-hour emergency period. The California statute's failure to provide for mandatory judicial review of the hospital staff decision to certify his continued commitment on March 4, 1975, resulted in seven days of additional involuntary detention and medication.

On September 24, 1979, Judge Warren J. Ferguson of the U.S. District Court of California, on a motion for summary judgment, ruled that the lack of mandatory review for involuntarily detained gravely disabled persons violated due process. He ordered the defendant state mental health personnel to develop a "plan for the independent review of probable cause for detention beyond 72-hour emergency period of persons alleged to be 'gravely disabled'" (Doe v. Gallinot, 486 F.Supp. 983 (C.D. Cal. 1979)). Although the Court did not detail a specific plan in its decision, it did indicate that due process was safeguarded only by a probable cause hearing at which someone or some group independent of the hospital, although not necessarily a judicial officer, conducts an "evaluation to determine whether there is probable cause for detaining the person" (486 F.Supp. at 994).

Various efforts to develop a satisfactory plan were unsuccessful. In June 1980, the district court granted a preliminary injunction barring the involuntary confinement of gravely disabled persons beyond the 72-hour emergency treatment and evaluation period without a mandatory probable cause hearing.

> The defendants, their officers, agents, servants, employees, and attorneys, and those persons acting in concert with them, are hereby enjoined from detaining any person against his/her will, pursuant to California Welfare and Institutions Code Section 5200 et seq., under a diagnosis of "grave disability" as defined in Welfare and Institutions Code Section 5008(h), for a period exceeding the 72-hour emergency period authorized. . .unless a state initiated probable cause hearing which meets the approval of the court is provided. (Doe v. Gallinot, 657 F.2d at 1021 (9th Cir. 1981))

On February 3, 1981, the defendants appealed the district court's decisions to the United States Court of Appeals, Ninth Circuit. In its September 10, 1981 decision, the Ninth Circuit upheld the district court's ruling that "due process requires a probable cause hearing after the 72-hour emergency detention period for persons alleged to be gravely disabled. . ." and that such a hearing should be conducted no later than the seventh day of involuntary confinement (id. at 1025). Importantly, the Court relied on well-established precedent in testing challenged state procedures under a due process claim by balancing a number of factors including the "fiscal and administrative burdens that the additional or substitute procedural requirements would entail" (id. at 1022-1023, notation omitted).

After considering the protections of individual liberty interests, the Court turned to the question of whether "the benefits of a rule requiring a hearing in every instance where 14-day certification is sought are outweighed by the added burden on the state" (id. at 1023). The Court, while "mindful of these concerns" (id. at 1023), unfortunately, did not address this question directly, stating that the

burden was "largely hypothetical" because the district court did not detail or impose any specific form of mandatory probable cause hearing. The court seemed to imply, however, that constitutionally adequate procedures could be implemented without undue burden on state resources if probable cause hearings were not too formal and complicated. Indeed, because the appellant relied on speculations "based on an over-formal model" (id. at 1024), the court rejected the appellant's argument that the requirements for probable cause hearings would impose an undue burden.

> No more is required than an independent evaluation, by a neutral decisionmaker, of the determination to confine a person as "gravely disabled" for 14 days. Recent Supreme Court decisions indicate that a decisionmaker within the institution will often suffice. E.g., Vitek, 445 U.S. at 496, 100 S. Ct. at 1265, 63 L. Ed. 2d 567 (independent decisionmaker need not come from outside prison or hospital administration); Parham, 442 U.S. at 607, 99 S. Ct. at 2506, 61 L. Ed. 2d at 122 (staff physician sufficient if free to evaluate independently the need for treatment and mental and emotional condition). (Id. at 1024)

Thus, in ruling that constitutionally adequate probable cause hearing procedures could be implemented without undue burden on the state, the Ninth Circuit seemed to have relied not on the appellants' arguments about the burdens probable cause hearings would impose (the Court passed these off as largely hypothetical), but relied instead on two Supreme Court decisions (Vitek and Parham) suggesting flexibility in the construction of those hearings procedures, specifically, that a staff physician within the hospital might suffice as a neutral decisionmaker in such hearings.

The case was returned to the federal district court to provide the necessary injunctive relief consistent with this ruling. That the Ninth Circuit considered only the hypothetical burden as described by the appellants' speculations "based on an over-formal model," and that it suggested that someone within the institution, such as a staff physician, might serve as a neutral decisionmaker, is worth noting as we next turn to the standards for probable cause hearings set by the federal district court.

In an order dated January 20, 1982, Judge Ferguson of the U.S. District Court of California, Central District, articulated ten standards "to assist the parties in the formulation of a program which will meet minimum due process requirements." The fifth through the eighth standards are particularly relevant here:

> (5) All indigent patients must be provided by the State with an attorney or other person who is competent and independent and able to act solely in the patient's best interest. The plan for

representation shall not violate the State Bar Act or any other provision of state law. Law students may serve as a (sic) representative provided they are in a program authorized by the State Supreme Court.

(6) There must be an independent decisionmaker. That person must be either:

(a) a judicial officer,
(b) a court-appointed commissioner or referee,
(c) a state-qualified administrative law judge,
(d) a medical doctor, or
(e) a licensed clinical social worker with a minimum of 10 years' experience in mental health.

(7) The appointment, tenure, and compensation of the independent decisionmaker shall not be controlled by any person or agency of the Department of Mental Health.

(8) The procedure and burdens at the hearings shall be in accordance with the minimum due process procedures required by the State at hearings on petitions for writ of habeas corpus. (Doe v. Gallinot. No. CV76-107-F (C.D. Cal. Jan.20, 1982) (order denying motion))

The fifth and eighth standards set requirements that may appear formal, in a legal sense, to those non-lawyers in the designated mental health facilities in Los Angeles County who are given the responsibility of fashioning acceptable procedures. The sixth and seventh standard articulate requirements clearly more stringent than that cited by the Ninth Circuit opinion, that is, someone within the hospital may suffice as the neutral decisionmaker. Whether these seemingly more strict and formal standards set by the district court would constitute an undue burden on the state if and when the issue is relitigated by defendants (e.g., county hospitals) other than those party to the Doe v. Gallinot case (a possibility left open by the Ninth Circuit opinion, 657 F.2d at note 8) is a matter for speculation which we will not address here. Instead, given the legal context as described in this section, we turn in the next section to the impact of the Doe v. Gallinot case on the practice of involuntary detainment in Los Angeles.

THE PRACTICE

At the time of our study in Los Angeles County during the two-week period beginning February 15, 1982, Judge Ferguson's latest order had just been disseminated throughout the mental health-judicial community. Instead of causing refinements of already existing procedures and fashioning a uniform probable cause hearing process in Los Angeles County, Judge Ferguson's order seemed to bring efforts to comply with Doe v. Gallinot (i.e., a prompt mandatory hearing and review of involuntary commitment decisions) to a virtual standstill. Officials of Court 95 and

the mental health facilities in Los Angeles County appeared anxious, frustrated, and confused by the developments of Doe v. Gallinot. At the time we interviewed them shortly after Judge Ferguson's January 20, 1982 order, many appeared immobilized by the order and seemed content to be reactive and let the federal District Court patch together an acceptable probable cause procedure by means of legal experimentation. As will be discussed, we consider this reactive stance by those who best know the commitment system in Los Angeles to be unfortunate.

Prior to Judge Ferguson's latest order, probable cause hearing procedures fashioned to comply with Doe v. Gallinot varied considerably among mental health facilities in Los Angeles County. None of the three hospitals we studied seemed in compliance with Judge Ferguson's order. The probable cause determination at the University of Southern California (USC) Hospital consisted of nothing more, according to a staff member of USC's Institute of Psychiatry, Law and Behavioral Science, than an independent physician checking the available records of involuntarily detained patients. The patients' views were not represented by another person in these determinations.

At Metropolitan State Hospital a psychiatric social worker with 20 years of experience in the area of mental health serves as the independent decisionmaker (or "Doe hearing officer," as she is referred to by hospital staff) in probable cause hearings. The social worker, though not an official employee of the hospital, does work in the hospital as an employee of the Department of Mental Health. Hearings are held within seven days of the start of involuntary confinement. A Metropolitan State Hospital physician or social worker presents the case to the hearing officer in the presence of the patient. Failure to find probable cause to detain the person leads to either outright release or a change in the patient's status to voluntary hospitalization.

Interestingly, probable cause hearings in Metropolitan State Hospital were held only for those persons involuntarily detained as only gravely disabled (and not dangerous), a scheme which fails to satisfy the standard set by the District Court's latest order that probable cause hearings must be held for all persons certified as gravely disabled regardless of whether they meet other LPS Commitment criteria as well (id. at 1). Apparently, the District Court's ruling and the Ninth Circuit's affirmation were sufficiently ambiguous to allow the Metropolitan Hospital's interpretation that only those persons found gravely disabled, exclusively, were affected. While it seems clear from Judge Ferguson's January 20, 1982 order that grave disability, even in combination with dangerousness, must trigger a probable cause hearing, the applicability of hearing requirements to persons certified a "danger to self" or "danger to others" but not "gravely disabled" is still a matter of debate. While this issue was not before the courts in Doe v. Gallinot, it is likely to be litigated in the future. In practice, however, the issue may be already relevant. It is conceivable, for example, that hospitals, in order to avoid the burden of probable cause hearings, may tend to certify dangerousness to the exclusion of grave disability.

An administrator at Metropolitan State Hospital remarked that Gallinot had "created a mess." He claimed that hearing requirements had caused constant problems for the hospital administration, and seemed to be detrimental to therapy in many cases. He suggested that the decision signaled the beginning of a return to court commitments in California. "We're throwing out LPS," he said, "except for the length [short-term] commitment."

Until shortly before the District Court's January 20, 1982 order, Olive View Medical Center conducted approximately 30 probable cause hearings per month. All patients certified for 14 day treatment pursuant to Section 5250, not only those deemed gravely disabled, were provided hearings where a nurse-mental health counselor familiar with patient's rights issues served as the hearing officer. A patient advocate employed by the Department of Mental Health attended the hearings in the interest of the patient who was also present. A physician presented the case or provided a written report. Reportedly, all probable cause hearings at Olive View Medical Center terminated following the District Court's order.

On January 20, 1982, the District Court ordered the state to prepare a detailed plan for probable cause hearings within ninety days. Although some mental health officials feared that Court 95 would release patients "left and right" because of a failure to conduct probable cause hearings in compliance with the latest order, it seems unlikely that any such actions will be taken. The current judge of Court 95 stated that until he has more guidance from the District Court or until the court issues a final order in Gallinot, he will continue his present practice of denying motions that cases be dismissed because of a failure to conduct probable cause hearings.

As a practical matter, too many questions are left unanswered. Is the Doe v. Gallinot decision binding on private hospitals? Will county hospitals and other facilities not parties to the action in Doe v. Gallinot relitigate the probable cause hearing provisions? In the event that a treating mental health professional believes that a person is mentally ill, gravely disabled, and dangerous, but the hearing officer does not and subsequently releases the person, to whom does liability for wrongful release attach? Does a finding of probable cause constitute an automatic request for a writ of habeas corpus? Does a request for a habeas corpus review and a writ hearing within seven days of initial confinement make a probable cause hearing unnecessary or must the administrative probable cause review always precede judicial review? Are waivers of probable cause hearings contingent on judicial review of the patient's competence to waive the hearing, and if so, how and by whom is that review to be conducted? Alternatively, should waivers be a relatively easy matter for patients in order to prevent undue anxiety in patients unwilling to have a hearing? Are probable cause hearings to be matters of public record? What is the remedy for a failure to provide a probable cause hearing--immediate release from involuntary confinement or civil action against the detention facility? Finally, where is the mental health system to acquire the staff and fiscal resources

(notwithstanding that the courts have determined it should not impose an undue burden) to comply with Doe v. Gallinot?

Obviously, it is a relatively simple matter to construct a "what if" scenario and compile a long list of questions and vexing problems. We have no easy answers. We do fear the consequences of the frustrations, reticence, bureaucratic inertia, disorganization, or whatever it is that has kept those key persons in the mental health-judicial system in Los Angeles most knowlegeable about the commitment process in a very reactive stance vis-a-vis the federal District Court. In our opinion, prompt mandatory review hearings will be an inevitable part of the California involuntary commitment system of the future. No one to whom we spoke argued against the provision of such hearings. The right to a probable cause hearing in involuntary civil commitment cases has been acknowledged by a number of federal and state courts. Some courts have even acknowledged the desirability of such a hearing before a person is ever detained. A probable cause hearing provision would only bring the Los Angeles procedures into line with the procedures in most progressive states.

The crucial question seems to be one of resources. We fear that the mental health-judicial system will fail to be aggressively proactive in constructing acceptable probable cause hearing provisions and will let the federal courts literally patch together a procedure based on what is before them, and then impose upon the system provisions that are satisfactory to very few. This is not a criticism of the federal courts' and the Ninth Circuit's decision in Doe v. Gallinot. As suggested, the decision is in keeping with other federal and state court decisions; Judge Ferguson's January 20, 1982 order is responsive to the mental health system's need for guidance. The courts, however, are limited to issues before them, and it may be years before all the issues concerning probable cause review of involuntary civil commitment are brought before the courts. Even if this is accomplished, the result may be a cumbersome, costly, "overly-legalized" procedure, at a time of a trend to remove some cases from the adversary system to administrative or arbitration processes.

We have observed one jurisdiction's experience with probable cause determinations, beginning with the desire for a relatively informal testing of the involuntary hospitalization by administrative review, and ending with the provision of automatic adversarial probable cause hearings in all cases. This development in Columbus, Ohio is the topic of considerable debate and the cause of a great deal of dissatisfaction. Based largely on concerns for economy and efficiency (the same "fiscal and administrative burdens" weighted by the Ninth Circuit in Doe v. Gallinot, 657 F.2d at 1022-1023 (1981)), the majority of judicial and mental health personnel with whom we communicated in Columbus, Ohio were dissatisfied with their probable cause review procedures. The Columbus experience with these reviews is illustrative of the problems of an overly-formal model of probable cause hearings. Our comments about the Columbus probable cause review procedures, excerpted from Involuntary Civil Commitment in Columbus, Ohio (Williamsburg, Virginia: National Center for State Courts, 1982), are reproduced in Appendix B.

CONCLUSIONS AND RECOMMENDATIONS

At this writing, almost six years have passed since the issue of constitutionally required mandatory reviews of involuntary civil commitment was first before the courts in the case of Doe v. Gallinot. We cannot envision a retreat from the essence of the Federal District Court's ruling and affirmation by the Ninth Circuit (486 F. Supp. 983 (C.D. Cal. 1979), aff'd, 657 F2d. 1017 (9th Cir. 1981)), that a probable cause determination must be afforded every allegedly gravely disabled individual in connection with a certification for involuntary intensive treatment under the LPS Act. Even if, as one deputy public defender in Los Angeles put it, the "Proposition 13 chickens are roosting again," the federal courts will probably impose requirements for probable cause determinations on the mental health system that may prove to be a costly and cumbersome burden, notwithstanding the Ninth Circuit Court's opinion on that matter (id. at 1021-1024), unless those affected by the decision become aggressively proactive in fashioning acceptable probable cause procedures in Los Angeles County.

RECOMMENDATION: MENTAL HEALTH AND STATE COURT PERSONNEL, IDEALLY ACTING IN CONCERT, SHOULD STRIVE TO FASHION PROBABLE CAUSE HEARING PROCEDURES PROACTIVELY AND NOT ONLY IN REACTION TO FEDERAL COURT DECISIONS.

This recommendation is intended to encourage immediate, coordinated action between mental health and state court personnel. This action does not require time-consuming legislative reform. This is not to suggest, however, that legislative reform should not be a long-term goal. One reviewer of this recommendation in its original draft form stated that he, and many of his colleagues, believe that a need exists to revise the entire civil commitment system in California to address not only the probable cause hearing issue, but also to address many problems that have surfaced as a result of two decades of experience with the current commitment statutes. While such reform is pending, however, concerted, proactive cooperation between mental health and state court personnel can do much to fashion more fair, effective, and efficient probable cause hearing procedures.

CHAPTER V

FOURTEEN-DAY INVOLUNTARY HOSPITALIZATION

During the involuntary patient's 72-hour emergency hospitalization, hospital staff evaluate the patient, provide emergency mental health services, and decide whether release or continued hospitalization is appropriate. If the decision is made to certify the respondent for further hospitalization, a number of rights accrue to the respondent, including the right to contest continued hospitalization in court. This chapter is concerned with the procedure by which patients are certified for continued hospitalization, the manner in which they are informed of their rights, and the process by which habeas corpus relief may be sought.

CERTIFICATION FOR INTENSIVE TREATMENT

The California statutes provide that a person hospitalized for 72 hours for evaluation and treatment may be certified for not more than 14 days of involuntary intensive treatment under the following conditions: the facility staff have analyzed the person's condition and found that he or she, as a result of mental disorder, represents a danger to self or others or is gravely disabled (unable to provide for own food, clothing, or shelter); the person has been advised of, but has not accepted, voluntary treatment; and the facility is equipped and staffed to provide treatment (5250). A notice of certification must be signed by two people: the professional person in charge of the facility in which the mental health evaluation pursuant to the 14-day certification was conducted, or his or her designee (who must be a physician, or a licensed psychologist with a doctoral degree in psychology and at least five years of post-graduate experience in the diagnosis and treatment of emotional and mental disorders), and a physician (board qualified psychiatrists, if possible) or a psychologist (licensed and with at least five years of post-graduate experience in the diagnosis and treatment of emotional and mental disorders) who participated in the evaluation (5251). The notice must be personally delivered to the person certified, and a copy must be provided to the court, the respondent's attorney, the district attorney, the public defender, the facility providing treatment, and the State Department of Mental Health (5253). Statute further requires that the person delivering the copy to the respondent must inform the person of his or her legal right to judicial review by habeas corpus and the right to counsel (court appointed counsel for indigents) (5252.1).

The procedures for initiating the certification for intensive treatment vary in some measure from facility to facility in Los Angeles County. At Metropolitan State Hospital, respondents who are admitted for 72-hour evaluation and treatment are examined the day of admission or the following morning by a "ward team" consisting of one member of the nursing staff, a physician, a social worker, and a psychologist. These professionals evaluate the respondent and determine whether he or she should be certified for an additional 14-day intensive treatment period.

If the ward team believes that the respondent does not meet the commitment criteria, they order and effect the respondent's immediate release. If the decision is to certify, the team begins treatment and discharge planning immediately. Staff at Metropolitan State Hospital noted that because of statute (5328.1), which denies the facility the authority to notify other persons of the patient's admission in the absence of the respondent's authorization, it sometimes is difficult for hospital staff to generate an adequate social history or begin appropriate discharge planning.

At Olive View Mental Health Center, respondents admitted for 72-hour evaluation and treatment are promptly evaluated by a physician, a patient financial services worker, a mental health counselor (a registered nurse), a psychiatric social worker, and a caseworker. If the respondent is certified for a 14-day intensive treatment period, the mental health counsel prepares a treatment plan within 72 hours of admission.

NOTICE OF RIGHTS AND WRIT OF HABEAS CORPUS

In Thorn v. Superior Court (1 Cal. 3d 666, 83 Cal. Rptr. 600, 464 P. 2d 56 (1970)), the California Supreme Court held that a patient may be involuntarily hospitalized for up to 17 days (three days for evaluation plus 14 days of intensive treatment) without a hearing if a counselor visits the patient and advises him or her of his or her rights. State law permits a local determination of who should contact the patient. The agencies which might conduct "Thorn interviews" include the Public Defender's Office and the Mental Health Counselor's Office. In Los Angeles, four mental health counselors, serve as "Thorn officers." These individuals have advanced training and experience in psychiatric social work. One reviewer of an earlier draft of this report suggested that, although these counselors are extremely hardworking and do an excellent job, they have a "treatment orientation" and may not be as aggressive in advising a voluntarily detained person of his or her right to release as perhaps a patient advocate or public defender might be. Whenever a respondent is certified for a 14-day period of intensive treatment, personnel of the certifying facility notify by telephone the Office of the Mental Health Counselor at the court, whereupon the mental health counselor asks the facility representative if the patient has indicated an interest in filing for habeas corpus. Reportedly, because of the size of Los Angeles County and the large number of facilities that accept involuntary patients for evaluation and treatment, and because the Office of the Mental Health Counselor is understaffed, it has been difficult to ensure that every patient be seen personally by a mental health counselor. All patients who directly request or otherwise indicate any interest in filing a writ of habeas corpus, however, are visited by a mental health counselor. It is estimated that, overall, approximately 90 percent of all certified patients are visited personally by a mental health counselor or "Thorn officer" of the court.

At Metropolitan State Hospital, where, reportedly, the majority of involuntary patients in Los Angeles County are hospitalized, mental health counselors make daily visits and meet with every new involuntary

patient. The mental health counselor explains to the respondents their legal right to a judicial review by habeas corpus, their right to the assistance of counsel (at state expense if they are indigent), and their right to become voluntary patients. Mental health counselors carry forms for preparing writs of habeas corpus, and, if a patient wishes to file a writ, the counselor will complete it at the hospital. Further, the counselors carry docket numbers with them and set hearings while at the hospital. Typically, the counselor serves the hospital with notice of the hearing before leaving the facility. Usually, this notice is presented to a nurse on the ward.

It was reported to the authors that in every facility for involuntarily committed persons, a notice is posted indicating the name, telephone number, and address of the Office of the Patients Rights Advocate. Additionally, every patient is presented with a copy of a booklet explaining patients rights. According to a representative of the Office, the most frequently received complaint (representing 17 percent of all complaints) is that involuntary patients are not adequately made aware of their right to request a writ of habeas corpus. When the Office receives notice that a particular patient is interested in pursuing release, an advocate from the office will determine the patient's status (voluntary, 72-hour, 14-day, etc.) and ask the patient whether he or she is aware of the writ of habeas corpus procedure. If the patient indicates an interest in filing a writ, the advocate will contact a mental health counselor in Department 95.

An attorney in the Office of the Public Defender complained that, because counsel for the respondent is not appointed until a writ of habeas corpus is filed, and because some respondents are not visited by mental health counselors (and, consequently, do not file writs), for some patients the 17-day hospitalization may not be effectively challenged because the public defender does not have the opportunity to become involved. Furthermore, the failure of a mental health counselor to meet with a respondent may not be challenged because public defenders do not become involved in cases unless such a visit has occurred.

CONCLUSIONS AND RECOMMENDATIONS

The procedures specified by California statute and case law for the certification of patients for 14-day intensive treatment are generally sound. The requirement that more than one mental health professional participate in the certification decision is particulary praiseworthy.

That the person delivering a copy of the notice of certification to a respondent certified for intensive treatment is required to explain to the respondent his or her legal rights, is an important feature of the California procedure. Although statute does not require a specific office to inform the certified person of his or her rights, the Office of the Mental Health Counselor has been carrying out this statutory requirement in most parts of the county. That not every patient is visited is a weakness in the Los Angeles County system for involuntary

commitment. Although it may require the allocation of additional funds, it is important that measures be taken to ensure that every respondent is visited by a mental health counselor.

RECOMMENDATION: THE OFFICE OF THE MENTAL HEALTH COUNSELOR SHOULD BE PROVIDED WITH THE RESOURCES NECESSARY TO ENSURE THAT IT IS CAPABLE OF SATISFYING ITS OBLIGATION TO VISIT AND EXPLAIN RIGHTS TO EVERY INVOLUNTARY PATIENT CERTIFIED FOR INTENSIVE TREATMENT. FURTHERMORE, THE OFFICE SHOULD ESTABLISH PROCEDURES THAT WILL ENABLE IT TO SATISFY THIS OBLIGATION.

CHAPTER VI

CONTINUED INVOLUNTARY HOSPITALIZATION

Involuntary patients in California who have been certified for a 14-day period of involuntary intensive treatment beyond the initial 72-hour emergency hold may be subject to recertification for an additional 14-day period of intensive treatment if suicidal, to a 90-day postcertification period of intensive treatment if dangerous to others, or to a 30-day temporary conservatorship (which may be followed by a one-year conservatorship, renewable annually) if gravely disabled.

CONTINUED INTENSIVE TREATMENT OF SUICIDAL PERSONS

The California statutes provide that, at the expiration of the 14-day period of intensive treatment, any person who during the 14-day period or the preceding 72-hour emergency evaluation and treatment period, as a result of mental disorder, threatened or attempted to take his or her own life or who was detained for mental health evaluation and treatment because he or she threatened or attempted to take his or her own life, and who continues to present an imminent threat of suicide, may be recertified for further intensive treatment for an additional period not to exceed 14 days (5260). The requirements concerning mental health evaluation for recertification and notice of recertification are essentially the same as those applying to the initial certification for 14-day intensive treatment, except that the allegations made by the mental health professionals must be supported by accompanying affidavits.

Reportedly, recertification is not frequently pursued in Los Angeles County. A staff member of one hospital reported that a respondent must be imminently suicidal before he or she will be recertified. He said that, as a practical matter, the respondent must have committed an overt act during the period of hospitalization; suicidal ideations are insufficient to effect recertification for continued hospitalization.

Respondents recertified for intensive involuntary treatment have the right to file for a writ of habeas corpus. As with initial certifications (see Chapter V), most patients are visited by mental health counselors, who advise them of the rights to file a writ of habeas corpus and to be represented by counsel.

POSTCERTIFICATION OF IMMINENTLY DANGEROUS PERSONS

The California statutes provide that at the expiration of the 14-day period of intensive treatment, a person may be confined for further treatment for an additional period not to exceed 90 days if he or she (1) has threatened, attempted, or inflicted physical harm upon another person after having be taken into custody for evaluation and treatment, and who, as a result of mental disorder, presents an imminent threat of substantial physical harm to others, or (2) has attempted or

actually inflicted physical harm upon another person, that act having resulted in his or her being taken into custody, and who presents, as a result of mental disorder, an imminent threat of substantial physical harm to others (5300).

To initiate postcertification procedures, the mental health professional in charge of the facility must petition the Superior Court for an order of postcertification. The petition must be supported by affidavits describing the behavior that indicates that the respondent meets the criteria for postcertification. Copies of the petitions and the affidavits must be provided to the respondent on the same day as they are filed in the court (5301). The respondent must be advised of his or her right to be represented by an attorney and to demand a jury trial (5302). A hearing must be conducted within four court days (weekdays excluding holidays) of the filing of the petition. If at the time of the hearing, the respondent or his or her counsel requests a jury trial, the trial must commence within ten court days of the filing of the petition for postcertification treatment, unless the respondent's counsel requests a continuance, which may be granted for a maximum of ten additional court days. The burden of proof, beyond a reasonable doubt, is on the state. Finally, the decision of the jury must be unanimous in order to effect continued hospitalization on the basis of dangerousness to others (5303).

Postcertification is virtually never pursued in Los Angeles County. A mental health professional in one facility stated that he had never applied for a 90-day postcertification and did not intend to in the future. He said that, as a practical matter, if a respondent commits a criminal act while in the hospital, the hospital will notify the sheriff's department. He suggested that he simply did not want "that type of patient" in his hospital. He noted, incidentally, that the Los Angeles Jail has an inpatient facility for felons who are committed for 72-hour evaluation and treatment and 14-day certification for involuntary treatment.

Some people in Los Angeles suggest that one reason the post-certification procedure is rarely used is that a conservatorship is relatively "easier" to obtain for many of the respondents and results in a longer (one year) period of hospitalization. Presumably, to remove this disincentive to using postcertification, a bill (Assembly Bill 351) was introduced in the California legislature to raise the maximum period of hospitalization on a postcertification from 90 days to one year. The bill would require hospitals to have treatment available for patients on a postcertification for dangerous respondents, but would permit refusal of treatment. "Amenability to treatment is not required. . . .Treatment does not mean that the treatment be successful or potentially successful, and it does not mean that the person must recognize his or her problems and willingly participate in the treatment program" (AB 351, p.3, emphasis in original).

Some individuals in Los Angeles County were highly critical of AB 351, referring to it as "the new preventive detention." It was suggested that postcertification hospitalization provided by the bill

would result in many beds being filled by patients who are not being treated, which will, in effect, deny beds to other patients who can benefit by treatment. This would occur despite the fact that the bill would place an affirmative obligation on the facility to treat the underlying cause of the mental disorder of a person committed under its provision.

The district attorney in Los Angeles County insists on screening those postcertification petitions that are filed due to the difficulty of proving dangerousness to others during involuntary hospitalization. One observer suggested that of approximately 12 postcertification petitions filed per year, only about one or two survive the screening and subsequently are subjected to judicial review.

TEMPORARY CONSERVATORSHIP AND FULL CONSERVATORSHIP

The California statutes provide that a conservator of the person and/or the estate may be appointed for any person who is gravely disabled as a result of mental disorder (5350). For the purposes of civil conservatorship, "gravely disabled" is defined as "a condition in which a person, as a result of a mental disorder, is unable to provide for his basic personal needs for food, clothing, or shelter. . . ." (5008). With a number of important exceptions, the procedures for establishing, administering, and terminating conservatorships are the same as those provided in probate conservatorships (Cal. Prob. Code, Section 1400 et seq.). One important exception is that the person for whom conservatorship is sought is guaranteed the right to demand a court or jury trial on the issue of whether he or she is gravely disabled (5350). Requests for a trial must be made within five days following a hearing on the conservatorship petition. No hearing need be held if the proposed conservatee demands a court or jury trial before the date of the hearing. The court or jury trial must commence within ten days of the date of the request, except that continuances are permitted for up to fifteen days upon the request of counsel for the proposed conservatee (5350).

Conservatorship proceedings are begun when the professional person in charge of a facility providing evaluation or intensive treatment makes a recommendation of conservatorship to the officer providing conservatorship investigation for the county in which the proposed conservatee is a resident or was a resident prior to admission to the facility (5325). The statutes provide that such a professional may initiate conservatorship proceedings for a respondent who is not a patient as well; however, as a practical matter, this rarely is done in Los Angeles County. If the official providing conservatorship investigation concurs with the recommendation of the professional person who initiated conservatorship proceedings, the official may petition the Superior Court to establish conservatorship (5352). If the professional person in charge of a facility providing 14-day intensive treatment recommends conservatorship, the proposed conservatee may be held in that facility for a period not to exceed three days beyond the 14-day period for intensive treatment if such additional time is necessary for the

filing of the petition and for the establishment of such temporary conservatorship by the court (5352.3). In Los Angeles County, a 48-hour "grace" period generally is recognized--that is, at the end of the 14-day period of intensive treatment, the facility may hold the person for an additional 48-hours to allow the court to process the temporary conservatorship; ordinarily, this is only done if the fourteen days were to expire on a weekend or a holiday.

If temporary conservatorship is indicated, it may be pursued as an alternative to full conservatorship. The statutes provide that the court may establish a temporary conservatorship for a period of up to thirty days on the basis of the report of the officer providing conservatorship investigation or on the basis of an affidavit of the professional person who recommended conservatorship (5352.1). As a practical matter in Los Angeles County, nearly all conservatorship proceedings begin with temporary conservatorship.

The procedure followed in most facilities in Los Angeles County for the initiation of conservatorship proceedings begins during a respondent's fourteen-day involuntary hospitalization for intensive treatment (see Chapter V). Proceedings are initiated by an application or conservatorship investigation. The application, signed by two physicians, includes their diagnoses and a description of the respondent's behavior which indicates that conservatorship is appropriate. Ordinarily, this application is mailed first to the Office of the Public Guardian in downtown Los Angeles. Metropolitan State Hospital delivers its applications to the public guardian in Department 95, who in turn sends them to the downtown Office of the Public Guardian. According to representatives of Department 95, all applications are subsequently forwarded to Department 95 in essentially the same form in which they were originally submitted to the Office of the Public Guardian. It appears that, at the least, the downtown Office of the Public Guardian serves merely as an administrative control for conservatorship applications filed in Los Angeles County.

Upon receipt of an application from the downtown public guardian, the courthouse public guardian in turn delivers it to the Office of the County Counsel for further action. Although a number of people in Los Angeles believe that the public guardian serves a screening function, perhaps removing petitions that appear to have no merit, it appears that all applications for conservatorship investigation received by the public guardian are forwarded to the county counsel's office for further action. The county counsel may refuse to file cases that lack merit. Indeed, the county counsel, reportedly, screens and removes a large percentage of temporary conservatorship petitions. Given that the county counsel represents the public guardian in conservatorship proceedings, it appears that the county counsel's exercise of discretion in the filing of cases serves the public guardian's interest by screening unmeritorious applications.

For applications that appear meritorious, the County Counsel's Office prepares a petition for temporary conservatorship and delivers it

to the Judge of the Superior Court, Department 95, for signature. The County Counsel's Office, ordinarily prepares petitions for conservatorship on the day the petitions are received. Also, the Judge, reportedly, issues an order of temporary conservatorship the same day he receives the petition. Orders of temporary conservatorship are issued in virtually every case for which a petition is filed by the Office of the County Counsel.

A judge of the Superior Court reported that petitions for temporary conservatorship typically were presented to him for signature without the expectation that he would review their validity. A mental health counselor in Department 95 suggested to him that such review would be unduly time-consuming and burdensome to administration and processing of the petitions and cases. The judge stated that a number of petitions were presented to him on his first day on the bench, and, when he refused to sign without having reviewed the petitions, the court officer who had delivered them simply gathered up the petitions and left the room. This judge stated that he did not see the same petitions again.

Statute in California provides that temporary conservatorships ordinarily expire automatically at the end of thirty days, unless prior to that date the court conducts a hearing on the issue of grave disability. If the proposed conservatee requests a court or jury trial on the issue of grave disability, the court may extend the temporary conservatorship for up to six months for disposition by the court or jury trial (5352.1).

After the temporary conservatorship is established, a hearing is scheduled for 16 to 24 days later to determine whether a full, one-year conservatorship should be ordered. Reportedly, the hearing is always set a few days before the expiration of the thirty day temporary conservatorship period so that if the case could not be disposed of at the hearing, a continuance within the thirty day period would be possible. During the period of the temporary conservatorship, the temporary conservatee may file a writ of habeas corpus. Procedures relating to the filing of the writ and the subsequent hearing are the same as those relating to writ proceedings during the 14-day period of intensive treatment (see Chapter V). Writ hearings are held in Department 95, before the same judge who hears writs filed by respondents hospitalized for 14-day periods of intensive treatment.

During the period of temporary conservatorship, a Deputy of the Public Guardian's Office conducts an investigation to determine the respondent's suitability for continued conservatorship. The Deputy reviews the conservatee's records and speaks with the treating physician, the nurses at the mental health facility, and the conservatee. The Public Guardian's Office employs nine deputies who are solely responsible for investigating conservatorship. Additionally, the public guardian's office employs approximately 10 LPS-approved deputies to serve as conservators. Each deputy has a "caseload" of approximately 125 to 150 conservatees. The deputy public guardian responsible for the conservatorship investigation is charged by statute with the responsibility of

investigating all available alternatives to conservatorship and recommending conservatorship to the court only if no suitable alternatives are available (5354).

If the Deputy Public Guardian determines that the temporary conservatee is gravely disabled and suitable for a "full" conservatorship, he or she will submit a report to the court indicating the results of the investigation. The California statute provides that the report must be comprehensive and contain all relevant aspects of the person's medical, psychological, financial, family, vocational, and social condition, and all available information concerning the person's real and personal property (5354). Reportedly, even if the Deputy Public Guardian determines that a temporary conservatee is not suitable for continued conservatorship, the Public Defender may insist that the County Counsel proceed and present a case for conservatorship. Apparently, this occurs only in criminal cases, however, if the Public Defender is interested in the continued commitment of someone found incompetent to stand trial or not guilty by reason of insanity.

Both hospital and court personnel report that as many as three-fourths of the temporary conservatees are released before a full conservatorship hearing is held. It was suggested that a temporary conservatee may be released during the temporary conservatorship for any of a number of reasons: (1) the conservatee may have improved to the point that he or she no longer was gravely disabled; (2) the conservatee may have chosen to become a voluntary patient; (3) a "reasonable alternative" to conservatorship may have been found; or, (4) the treating physician may simply have wished to avoid court proceedings and, therefore, discharged the patient. Professional literature has suggested that temporary conservatorship is frequently pursued by treating physicians solely to extend the opportunity to treat a conservatee rather than to investigate and determine suitability for conservatorship. That is, some physicians apply for a temporary conservatorship with no intention of following through with conservatorship proceedings.

The California statute provides that full conservatorship must automatically terminate one year after the appointment of the conservator; however, 30 days of temporary conservatorship is not included in the one-year period (5361). At the expiration of the one-year conservatorship, the conservator may petition the court for his or her reappointment as conservator for an additional one-year period. The statutes provide that this petition must include the opinions of two physicians or licensed psychologists that the conservatee remains gravely disabled as a result of mental disorder (5361). A petition for reappointment of the conservator must be transmitted to the facility in which the conservatee is hospitalized at least thirty days before the termination date. The facility may detain the conservatee after the end of the termination date only if the conservatorship proceedings (for reappointment) are begun but not completed and the court orders the conservatee to be held until the proceedings have been completed (5361).

In Los Angeles County, the court clerk maintains a "tickler" system to provide timely notification to the conservator when a rehearing or a reappointment is due. As a practical matter, reappointment petitions typically are submitted approximately two months before the end of a conservatorship period; cases usually are heard at least one or two weeks before the end of that period. Some of the individuals we interviewed stated that even if a conservatorship has expired, if a petition for reappointment is filed before the conservatorship period has formally expired, a reappointment hearing is held anytime within thirty days of the filing of the petition for reappointment. Apparently, in such cases, holding the conservatee pending completion of the reappointment proceeding does not require formal court action.

Statute provides that the conservatee may at any time petition the court for a rehearing concerning his or her conservatorship status. Petitions for rehearing, however, may be submitted only once every six months (5364). Reportedly, the rehearing procedure varies throughout the state. The procedure in Los Angeles County will be discussed in the next chapter.

CONCLUSIONS AND RECOMMENDATIONS

Additional Hospitalization and Intensive Treatment of Suicidal Persons

Apart from a few complaints that it is unduly restrictive (fails to provide for continued hospitalization of persons who show signs of dangerousness to self but who have not threatened or attempted suicide), the procedure for recertification of suicidal persons for a maximum of 14 additional days of involuntary intensive treatment is highly regarded by professionals in Los Angeles County. A number of persons, however, expressed concern that an additional recertification for even more intensive treatment (apart from conservatorship) was not available.

The requirement that allegations made by the mental health professionals signing the notice of recertification be supported by accompanying affidavits is an important feature of the procedure, given that evidence of a threat or attempted suicide is required. Finally, the availability of habeas corpus relief, regardless of whether a writ hearing was held during the original fourteen-day period, is important given the passage of time and different criteria applicable in recertification proceedings.

Postcertification of Imminently Dangerous Persons

Postcertification for dangerousness to others is extremely unpopular in Los Angeles County, primarily because it is generally believed that it is virtually impossible to prove, beyond a reasonable doubt, that someone is dangerous to others. Indeed, the professional literature is rife with demonstrations that psychiatric predictions of future violence are wrong more often than they are right. Further, the fact that conservatorship is available as an alternative and provides for a longer period of hospitalization stands as a disincentive to pursuing

postcertificaton as opposed to conservatorship. Despite this, the proposed legislation that would raise the maximum period of hospitalization on a postcertification for dangerousness to others to one year is highly controversial in Los Angeles. Given that the proposed legislation (AB 351) excepts the postcertification procedures from the requirement attaching to other involuntary hospitalization proceedings that the patient be treated, many see it merely as a convenient strategy for continuing to incarcerate persons showing criminal tendencies, rather than a procedure for assuring that persons in need of mental health treatment receive it. Further, some complain, to the extent that there is a shortage of psychiatric beds in Los Angeles County, that every bed filled by a patient who is not being treated, in effect, denies a bed to someone who might benefit greatly from hospitalization.

Currently, however, conservatorship is available as an alternative to postcertification for dangerousness only in specific statutorily defined instances. The respondent must have been found mentally incompetent under Section 1370 of the Penal Code and three facts must exist: (1) the indictment of information pending against the respondent at the time of commitment must charge a felony involving death, great bodily harm, or a serious threat to the physical well-being of another person, (2) the indictment of information has not been dismissed, and (3) as a result of mental disorder, the person is unable to understand the nature and purpose of the proceedings and to rationally assist counsel in his or her defense (5008(h)(2)).

Temporary Conservatorship and Full Conservatorship

The procedures followed in Los Angeles County for the establishment of a temporary conservatorship are generally to be commended. The practice of physicians who apply for conservatorship investigation presenting their diagnoses and a description of the patient's behavior, and indicating the appropriateness of conservatorship, provides some basis on which the court might decide whether to order a temporary conservatorship.

The procedure for establishing a temporary conservatorship is not without problems, however. The procedure of routing all conservatorship applications through the Public Guardian's Office seems to be wasteful, given that the Public Guardian apparently neither acts on, nor reformulates the application before forwarding it to the County Counsel's Office. The screening performed by the County Counsel is an important feature of this procedure. It serves to protect liberty interests of proposed conservatees and, at the same time, saves the public the cost of providing conservatorship services for indigent persons capable of providing for themselves without the assistance of a conservator.

A serious weakness in the procedure by which temporary conservatorships are created in Los Angeles County is the perfunctory review of applications for temporary conservatorship made by the court. It is the judge's responsibility to have before him or her all the

pertinent facts and to review carefully petitions for temporary conservatorship before signing the court order to effect conservatorship.

RECOMMENDATION: PETITIONS FOR TEMPORARY CONSERVATORSHIP, TOGETHER WITH ACCOMPANYING DOCUMENTATION, SHOULD BE PRESENTED TO THE JUDGE IN SUCH A MANNER AS TO ENCOURAGE MEANINGFUL REVIEW. FURTHERMORE, THE JUDGE SHOULD CAREFULLY CONSIDER THE ALLEGATIONS MADE IN THE PETITION AND APPLY THE CRITERIA FOR TEMPORARY CONSERVATORSHIP TO THESE ALLEGATIONS BEFORE DECIDING WHETHER TO ORDER TEMPORARY CONSERVATORSHIP.

Although it is important that procedures exist to promote the release of temporary conservatees before the establishment of a full conservatorship if circumstances have changed such that continued conservatorship is inappropriate, the suggestion that the temporary conservatorship device frequently is used by physicians essentially to "buy" time during which to treat patients who may not be gravely disabled (as defined by law) is disturbing. Such behavior is an inappropriate avoidance of the intentions of the LPS procedures.

RECOMMENDATION: THE COURT AND ITS OFFICERS, INCLUDING THE DISTRICT ATTORNEY'S OFFICE AND THE PUBLIC DEFENDER'S OFFICE, SHOULD, BY MEMORANDUM OR OTHERWISE, INSTRUCT THE MENTAL HEALTH COMMUNITY IN LOS ANGELES COUNTY REGARDING THE APPROPRIATE USE OF TEMPORARY CONSERVATORSHIP AND SHOULD DISCOURAGE ITS USE AS A CONVENIENT MECHANISM TO EXTEND THE INVOLUNTARY TREATMENT PERIOD FOR PERSONS NOT GRAVELY DISABLED.

One reviewer of this recommendation stated that the court and its officers have been providing such instruction to the mental health community, in both public and private forums, since the time that the LPS Act became law. For at least six years, the Program Services Bureau of the Los Angeles County Mental Health Department has sponsored bi-monthly meetings of the Justice/Mental Health Committee. Reportedly, the specific purpose of these meetings is to provide a forum for the court and its officers, and representatives of the designated psychiatric facilities throughout the community to discuss issues such as the proper use of applications for temporary conservatorship. Although treatment providers are strongly encouraged to attend, and notices of the meetings are mailed several weeks in advance to each designated facility, attendance of treatment providers is uneven. The reviewer suggested that after treatment providers attend, many do not return because they do not like what they hear concerning restrictions imposed by the law. Further, the reviewer suggested that the facilities "manipulate the existing laws and resources in this area as much as they possibly can and until something is done to stop them." As a result, judicial resources are expended unnecessarily in efforts to stop such abuses. The reviewer stated that it is not the court or its officers which need make further efforts to instruct the mental health community, but the mental health community which must accept the already proffered instruction.

The investigation conducted by the Public Guardian's Office during the period of temporary conservatorship appears quite adequate and thorough. The requirement that the investigating officer investigate all available alternatives to conservatorship and recommend conservatorship only if no suitable alternative is available is in compliance with the sound principle established by a number of court cases that involuntary commitment may not occur if a less restrictive alternative is available.

The practice of scheduling conservatorship hearings approximately one week before the expiration of the temporary conservatorship is to be commended. During hearings observed by the authors, proposed conservatees in a number of cases were unable to appear on the day of their hearings for various reasons (e.g., a measles outbreak in one of the county hospitals prevented the attendance of a number of proposed conservatees; others were unavailable because the bus transporting them from the hospital broke down on the way). New hearing dates still within the thirty day period of temporary conservatorship were set for many of these proposed conservatees.

Finally, the practice in Los Angeles County relating to the initiation of a reappointment of conservatorship seems sound. The procedure of the Los Angeles County Court Clerk of maintaining a "tickler" system to provide timely notification to the conservator when a rehearing or a reappointment is due is particularly noteworthy.

CHAPTER VII

JUDICIAL HEARINGS

As discussed in earlier chapters, LPS involuntary hospitalization and conservatorship may entail judicial hearings at various points in the proceedings (probable cause hearings, not yet widely implemented in Los Angeles County, will not be discussed in this chapter; but see Chapter IV). Writ of habeas corpus hearings are available upon request to respondents certified for fourteen days of involuntary intensive treatment following the initial 72-hour detention for emergency evaluation and treatment; respondents posing an imminent suicide threat recertified for an additional fourteen days of treatment; and respondents for whom a temporary conservatorship has been created. Furthermore, judicial hearings are mandatory in "postcertification" proceedings concerning dangerous respondents sought to be hospitalized for ninety days beyond the initial 17 days of involuntary hospitalization (3 days for the initial involuntary detention for evaluation and treatment, plus an additional 14 days for "certified" involuntary intensive treatment). Finally, a hearing also must be held before "full" LPS conservatorships may be created.

All "writ hearings," as the judicial hearings pursuant to writs of habeas corpus filed in the Superior Court, Department 95, are called, are conducted in essentially the same manner, regardless of the respondent's legal status. Conservatorship hearings are conducted in Department 95 before a commissioner or jury, and are different in many respects from writ hearings. Post-certification proceedings are pursued very rarely, and hearings reportedly almost never occur; accordingly, this chapter will focus on writ hearings and conservatorship hearings.

WRIT HEARINGS

Writ hearings are held in the Superior Court, Department 95 on a daily basis. A judge of the Los Angeles County Superior Court persides over these hearings. Judges rotate through the assignment to Department 95 approximately every two years although in the past some judges have remained longer for various reasons. The hearings are conducted in the courtroom in Department 95 and are open to the public.

Upon the filing of a writ of habeas corpus, the court must either release the respondent or order an evidentiary hearing to be held within two judicial days after the petition is filed (5276). Respondents are entitled to the assistance of counsel. As a practical matter in Los Angeles County, the Office of the Public Defender represents most respondents; only a very few are represented by private counsel. The Office of the District Attorney represents the state in writ hearings. Although the statutes in California provide that the respondent incurs and must pay the costs of such legal service if he or she is able, little effort is made to collect monies from respondents able to pay, reportedly because collection would be cumbersome and not cost-efficient (i.e.,

identifying and collecting from respondents able to pay would cost more than the amount recovered).

With regard to respondents certified for 14 days of involuntary intensive treatment, the respondent must be released if the court finds (a) that the respondent requesting release is not, as a result of mental disorder, dangerous to self or others, or gravely disabled, (b) that the respondent has not been advised of, or has accepted, voluntary treatment, or (c) that the facility providing intensive treatment is not equipped to provide treatment (or is not designated by Los Angeles County to provide intensive treatment) (5276). The criteria for recertification for an additional 14 days based on suicide danger are: (1) that the respondent requesting release presents an imminent threat of taking his or her own life; (2) that the respondent has been advised of, but has not accepted voluntary treatment; (3) that the facility providing additional intensive treatment can provide such treatment, is designated by the county to provide such treatment, and agrees to admit the respondent; and (4) that the respondent has, as a result of mental disorder, threatened or attempted to take his or her own life during the previous fourteen-day period of intensive treatment or the 72-hour evaluation period, or was detained for evaluation and treatment specifically because he or she threatened or attempted to take his or her own life (5260). Statute fails to specify the proper burden of proof for writ proceedings. Although there are those in Los Angeles County who take the position that the standard is "clear and convincing evidence," no appellate case has determined the issue and no trial judge in Los Angeles County has made a definitive statement concerning his or her feeling on the matter. The Public Defender's Office takes the position that the proper standard of proof is "beyond a reasonable doubt." The District Attorney's Office would require a "preponderance of the evidence." In any event, all agree that the burden of proof falls on the plaintiff to show that the patient need not be released.

Although the California statutes provide that the respondent requesting release may, upon the advice of counsel, waive the presence at the hearing of the mental health professionals who certified the petition for involuntary hospitalization, as a practical matter, a mental health professional appears to testify in virtually every case heard. Prior to judicial hearings each day, mental health professionals scheduled to testify in cases meet with attorneys from the District Attorney's Office and discuss the evidence they intend to present. At this time, the Deputy District Attorney may choose not to "prosecute" because a case is without merit or, simply, not strong.

Reportedly, until recently, attorneys from the Public Defender's Office often did not meet with their clients until the morning of scheduled hearings. Attorneys of the Public Defender's Office with whom we spoke stated that it recently had become necessary to refuse appointments in order to catch up with the cases for which the Public Defender's Office already was responsible. The consequence of this temporary cessation of appointments, reportedly, is that the Public Defender's Office is, at this writing, in a position to meet with most

respondents in advance of the hearing. Attorneys in the Public Defender's Office stated, however, that they had little time to do prehearing advocacy or investigation of less restrictive alternatives because of the large number of cases for which they were responsible and the limited resources that were available to their office. One official from the Public Defender's Office stated that, in view of the limited resources, Public Defenders should concentrate their abilities where they have the most effect, that is, in the courtroom. He stated that attorneys in his office consider themselves to be only part of a broad network of agencies which provide legal and guasi-legal service to people involved in involuntary hospitalizations. His office has found that other local organizations, such as the County Patient's Rights Office and the Mental Health Advocacy Service, Inc., are not only willing to work with the Public Defender in pre-hearing advocacy matters, but are more suited to this role. These other organizations, in turn, rely on the Public Defender's Office for courtroom advocacy under the LPS Act.

The court day on which hearings are scheduled begins with a calendar call, during which the court calls each case and determines whether some disposition can be made without a formal evidentiary hearing. Many cases are thus disposed because the respondents have chosen to become voluntary, have withdrawn their writs, or have been released since the filing of their petition. Cases not disposed of during the calendar call are held for hearing after the calendar call. In some cases, either the respondent or the testifying mental health professional is not present in the courtroom. When this happens, the case typically will be held until a second call of calendar, to allow the Public Defender or the District Attorney to contact the hospital and attempt to resolve the problem.

Writ hearings are conducted in an adversarial and a relatively formal manner, with questioning of witnesses by the District Attorney and the Public Defender, and with objections and argument. Although courtroom decorum for the most part is relatively formal, on occasions (particularly during breaks), attorneys were overhead joking and making references to respondents within easy earshot of respondents awaiting hearing and observers in the courtroom. Upon review of the original draft of this report, an official from the Public Defender's Office raised doubts that attorneys from that office behaved in this manner. The reviewer suspected that the authors had observed either an attorney from some other public office or a private attorney appointed to represent respondents when the Public Defender was unavailable. He stated that the Public Defender's Office has "a long-standing and very firm policy prohibiting such behavior," and that he personally would consider such behavior to be egregious for an attorney who represents mentally disabled individuals. His office has been aggressive in its criticism of individuals behaving in this manner and was instrumental in having one judicial officer removed from his position in the mental health courts because of such behavior. The reviewer stated that "[e]ven if no one else will do so, an attorney owes to the mentally disabled client a duty to respect his or her dignity as a human being."

In the hearings observed by the authors, the judge generally went to great lengths to explain his reasoning for a decision and seemed genuinely concerned that the respondent understood why he was deciding as he was. In a number of cases, the judge denied the writ of habeas corpus yet allowed the respondent to be released to his or her parents or some other person. When questioned about this practice, one attorney stated that, although nothing in the California statute specifically provides for such procedure (in essence, a commitment to a less restrictive alternative), it often works as a useful compromise between a rejection of the evidence supporting hospitalization and a denial of the respondent's potential for coping outside of the institution. The judge noted that the procedure was, in fact, a denial of the writ that results in a return of the respondent to the hospital. In effect, however, the denial gave notice from the court that if the treating professional felt that it was appropriate to release the patient to the particular relative or other person specified by the court, the court would join in the decision to release the respondent.

CONSERVATORSHIP HEARINGS

As indicated earlier, hearings must be held on all petitions for conservatorship within thirty days of the date they are submitted (5365). If the proposed conservatee demands a court or jury trial on the issue of grave disability, the demand constitutes a waiver of the hearing (5350). The court or jury trial should be within ten days of the demand. Statute requires that the court appoint the Public Defender or other attorney for the conservatee or proposed conservatee within five days after the date of the petition (5365). The Office of the County Counsel represents the people in conservatorship proceedings in Los Angeles County.

The criteria for establishing conservatorship are that the proposed conservatee is gravely disabled as a result of mental disorder and is unwilling to accept, or incapable of accepting, treatment voluntarily (5352). The burden of proof is on the state, the standard of proof is beyond a reasonable doubt, and a jury verdict must be unanimous (Estate of Roulet, Sup., 152 Cal. Rptr. 425 (1979)).

The conservatorship court in Los Angeles County (Superior Court, Department 95A) becomes involved in several types of proceedings: (1) original petitions (hearing on full conservatorships, generally following temporary conservatorships); (2) rehearings (hearings held as frequently as every six months, at the request of the respondent, to review the grounds for the conservatorship); (3) reappointment proceedings (annual proceedings to determine whether the conservatorship should be continued for another year); and (4) "Power 7" proceedings (at which the court considers whether to reduce or increase the conservator's powers with regard to placement of the conservatee in a locked facility). Also, the Commissioner, presiding at conservatorship hearings, sometimes will issue an order requiring that the case return to the court in a given period of time for further orders. For example, in a number of cases observed by the authors, the Commissioner ordered a conservatorship for ninety days

of involuntary hospitalization; at the end of the ninety days the Public Guardian was required to appear in court with a plan for the appropriate placement of the conservatee.

As is the case in writ hearings in Department 95, conservatorship hearings begin with a calendar call. Cases, typically, are either dismissed upon motion of the County Counsel or are placed on a second call for hearing following the calendar call. The conservatee or proposed conservatee is usually present at hearings. In some reappointment cases, however, the conservatee's presence is waived by the Public Defender. The Commissioner will allow the waiver only if the Public Defender has met and discussed his or her absence from the hearing with respondent. Also, in reappointment cases, the report of the mental health professional sometimes will be stipulated by the parties, and the professional need not testify. It should be noted, however, that the court requires the testimony of the mental health professional in all original conservatorship proceedings.

As indicated in the last chapter, a respondent placed in a conservatorship is entitled to a rehearing after six months. Although in the past there has been misunderstanding throughout the state concerning the burden of proof and right to jury trial at rehearings, a recent California Court of Appeals decision (Baber v. San Bernardino Superior Court, 113 Cal. App. 3rd 955, 170 Cal. Rptr. 353 (1980)) has held that the burden of proof in rehearings is on the conservatee by a preponderance of the evidence and that no right to jury trial attaches. The court held that while Section 5350 of LPS provides that the conservatorship proceedings shall be the same as in probate conservatorship--the conservatee has the right to a jury trial, and the conservator (or petitioner) has the burden of proof beyond a reasonable doubt--a rehearing (5364) is a unique proceeding with no counterpart in probate conservatorship (see Cal. Prob. Code, Sections 1400 et. seq.). Prior to Baber, the Public Defender's Office initially tried most cases without a jury, but exercised the right to demand a jury trial at rehearing, if appropriate. Because of Baber, and a recent California Supreme Court case (In Re Hop, 29 Cal. 3d 82, 171 Cal. Rptr. 721, 623 P. 2d 282 (1981)) which has been read to suggest that respondents in conservatorship proceedings may not be presumed competent to waive their rights, the Public Defender's Office in Los Angeles County concluded that it could not continue the practice of waiving a proposed conservatee's right to a jury trial at the initial conservatorship hearing. Soon after the Baber ruling, the Public Defender's Office began to demand a jury trial at initial hearings in every case. Reportedly, this overwhelmed the County Counsel's Office with an overload of cases. Consequently, County Counsel and the Public Defender settled on the practice of allowing the Public Defender to waive the right to a speedy jury trial at the initial hearing, try the case at the hearing, and recall the case for a rehearing at any time with the right to a jury trial. This compromised arrangement allows most conservatorship proceedings to be resolved at initial hearings, yet preserves the proposed conservatee's right to a jury trial. Although California has considered establishing this procedure by statute, that legislation did not pass.

Although certain sources in Department 95 indicated that jury trials are conducted with some frequency in the conservatorship court, one reviewer of an earlier draft of this report suggested that no more than eight to ten jury trials occur each year. Reportedly, most jury trials result in release.

If a conservatorship is created, the order appointing the conservator specifies whether the conservatorship is of the person only, or of the person and his or her estate. It specifies, further, that in determining the placement or residence of the conservatee, the conservator must choose the least restrictive setting which is appropriate for the conservatee's care and needs. Finally, it specifies the particular powers that the conservator may exercise with respect to placement of the conservatee and the particular disabilities to be imposed on the conservatee.

THE EXPERT WITNESSES

In both writ hearings and conservatorship hearings, the testimony of a mental health professional ordinarily is required. There is some debate in Los Angeles County whether the treating physician (as opposed to an examiner who may have no experience with the treatment of the respondent) should be required to testify. Reportedly, one facility in Los Angeles County, Metropolitan State Hospital, has a team of forensic examiners who testify in court cases. Typically, these psychiatrists will have examined the person in question prior to appearing in court; however, much (too much, argue some) of their testimony is based on charts and records produced by the treatment team.

Most of the persons we interviewed in Los Angeles County were in agreement that, in most cases, the treating physicians make much "better witnesses." One mental health professional, a member of a forensic team serving one hospital, thought otherwise. In jury cases, County Counsel stated that they make a special effort to have the treating physician present. Although statute requires that treating physicians testify, an LPS Act provision permitting waiver of the treating physicians' testimony makes possible the use of forensic examiners in their place. Most everyone we interviewed agreed that forensic examiners may be necessary to prevent the collapse of the system. They note that, if treating physicians were required to give testimony in every case, some physicians would be required to appear in court on a daily basis. Given that the courthouse for Department 95 is located in an industrial section in Los Angeles as far as thirty to forty miles from some mental health facilities, such a requirement could seriously threaten some physicians' opportunity to treat patients.

To improve the quality of forensic mental health examination and testimony, administrators of Metropolitan State Hospital are preparing an education and training program for their forensics staff. Noting the difficulty many mental health professionals encounter in the courtroom, many people in Los Angeles welcome the more effective use of forensic examiners. Others feel very strongly, however, that, because much of the

evidence presented by the forensic examiner in testimony is information generated by the treatment team, the respondent should not be denied the opportunity to cross-examine the members of the treatment team.

CONCLUSIONS AND RECOMMENDATIONS

Writ Hearings

The practice in Los Angeles County of operating a court exclusively for mental health proceedings is unique and praiseworthy. Although some people in Los Angeles complain that the absence of fresh faces among the attorneys working in the court discourages the introduction of new ideas and promotes the development of a hierarchy authority to influence the outcomes of most cases, most people would agree that this continuity of professionals results in a much higher level of competence in the area of mental health law. In other cities throughout the country in which the project team of the Institute on Mental Disability and the Law have studied commitment procedures, it was not unusual to find attorneys (and even judges) who do not understand the commitment laws by which the procedures are operated.

The Public Defender's Office in Los Angeles County has attempted to achieve a balance by retaining part of its staff on a relatively permanent basis and by regularly rotating the rest of the staff. Under the current plan, the Head Deputy Public Defender and two trial attorneys are "permanent." Each of the five or six "temporary" attorneys rotate into the division for 18 months. An official from the Public Defender's Office stated that it takes approximately six months for an attorney to become fully trained and capable of handling any mental health case coming before the court. After that period, the Office and its clients receive the full benefit of a trained lawyer. This staffing procedure provides a basis for the infusion of new ideas in the court while maintaining an underlying continum of experience.

The District Attorney's Office practice of arranging interviews with mental health professionals scheduled to testify is to be commended. It enables the Deputy District Attorney to receive current information regarding the respondent's condition and allows him or her the opportunity to screen out cases in which continued hospitalization is inappropriate. On the other hand, the failure of attorneys in the Public Defender's Office always to meet with their clients prior to the day of the hearing is a weakness of the commitment procedure in Los Angeles County. An official from the Public Defender's Office stated that their attorneys are only able to meet with their clients the day before a hearing in about fifty percent of their writ cases. Reportedly, these attorneys are able to do this when they receive the full two days advance notice required by statute. Because the Mental Health Counselors actually file the writs, the Public Defender is unable to control when notice is given. Without adequate advance notice, prehearing preparation is often impossible. The above-mentioned official suggested that the solution to the notice problem is to fund the Public Defender's Office so it can file the writs itself. The appropriate allocation of resources in

a commitment system, however, is a difficult matter. That Public Defenders have little time or opportunity to become involved in prehearing advocacy, or investigation of less restrictive alternatives, is cause for concern. It would be presumptious, on the basis of our limited study, however, to recommend that the allocation be reformulated to enable the Public Defender's Office to take a larger prehearing role. Nonetheless, because of its strained resources and because of inadequate advance notice, the Public Defender's Office may be unable to provide the quality of legal counsel that the professional literature suggests is necessary.

The typical court proceeding in Department 95 itself is relatively straightforward and appears to be conducted in such a manner as to ensure that credible evidence is presented and due consideration is given to the competing interests represented. As in all the jurisdictions studied by the Institute's project team, courtroom decorum could be improved, however. The public image of the courts suffers when attorneys and officers of the court make light of the proceedings to an audience of respondents and other observers. This is especially true in involuntary hospitalization proceedings, given the special sensitivity of many respondents and the emotional pressure felt by relatives of respondents in these proceedings. The long-standing policy of the Public Defender's Office prohibiting such behavior is praiseworthy. The following recommendation is intended to encourage continued enforcement of this policy not only in the Public Defender's Office but among all public offices and agencies in Los Angeles County, and to encourage other participants in the Los Angeles County mental health-judicial system to solicitously recognize the solemness of hearings conducted during the commitment process.

RECOMMENDATION: THE COURT AND ITS OFFICERS SHOULD BE SENSITIVE TO THE COURT'S PUBLIC IMAGE AND SHOULD STRIVE TO OBSERVE PROPER DECORUM DURING COURTROOM PROCEEDINGS.

Conservatorship Hearings

The practice of the conservatorship court Commissioner to frequently issue a conservatorship order of limited duration, to allow an early review of progress of the case, is to be highly commended. This practice encourages conservators to attend to their cases and assess the appropriateness of particular treatments or living arrangements made for the conservatee on a periodic basis. This is particularly important if the initial order of conservatorship provides the conservator with the power to place the conservatee in a secure facility. It is generally agreed that this power should be given to the conservator only when absolutely necessary. The authority to place a conservatee in a locked facility has potentially negative consequences in addition to the obvious curtailment of the conservatee's liberty. The conservator may feel some loss of responsibility (and corresponding loss of incentive to track the conservatee's progress) with the placement of the conservatee in a secure mental health facility. Finally, the compromise between the District

Attorney's Office and the Public Defender's Office, permitting the Public Defender to waive his or her client's right to a speedy jury trial, try the case at the hearing, and recall the case for a rehearing before a jury at any time, represents an excellent solution to a difficult legal problem.

The Expert Witnesses

Although most commentators who have considered the question agree that it is important that the defense in a commitment proceeding have the opportunity to cross-examine members of the team treating the respondent, the use of teams of forensic examiners has obvious practical utility in Los Angeles County. The concern of many that if treating physicians were required to appear in every case, little time would be left for treatment, is difficult to rebut in a county where mental health facilities may be thirty or forty miles from the courthouse. It is important, however, that whoever testifies--treating psychiatrist or forensic examiner--has thoroughly examined the respondent and has thoroughly reviewed the respondent's records prior to testimony.

Given the reluctance of many mental health professionals to testify in court and the ineffectiveness with which some present their findings, the use of forensic examiners may have advantages. To the extent that mental health professionals responsible for appearing in court receive training in mental health law, the quality of mental health testimony may improve. Of course it can be argued, and it has been argued successfully in some jurisdictions, that all mental health professionals eligible to evaluate patients for the purpose of involuntary hospitalizaton proceedings be trained and certified in the techniques of forensic mental health evaluation. In any event, the development of a special forensic expertise among those mental health professionals specially designated to testify in court may compensate to some extent for the failure of members of the treatment team to appear in court.

APPENDIX A

STUDY METHODS

This appendix describes the methods used in the first phase of the national project undertaken by the research staff, as well as in the research specific to Los Angeles County.

Literature Review

Beginning in January, 1981, the project staff reviewed professional literature on the topic of mental health law, especially that particularly germane to the involuntary civil commitment of allegedly mentally ill adults. The initial period of review lasted for approximately two months, although literature was reviewed continually throughout the initial eighteen-month 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 locating valuable literature.

Just prior to the meeting of the national advisory board in April 1981, 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 this 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.; 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 advice 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.

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 formed a basis for the major product of the first phase of the project, Provisional Substantive and Procedural Guidelines for Involuntary Civil Commitment, published in July 1982. 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 five funded project states: Illinois, Ohio, North Carolina, New York, and California.

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 when appropriate.

Preliminary Site Visit

A preliminary visit was made to four of the funded project sites. Staff members met with judges, court personnel, attorneys, and mental health professionals. The preliminary visit served several purposes. First, the participants in the civil commitment systems told staff their perceptions of how the systems worked. Cooperation was pledged for the research project. The people in Los Angeles (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 generously offered their help.

The individuals with whom we met during the preliminary site visit identified the agencies and institutions in Los Angeles County 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 deemed important or knowledgeable in a particular area were also identified.

No visit to Los Angeles was made; instead, the purposes of the preliminary site visit were accomplished by telephone contacts. This change in approach was justified by the experiences gained in preliminary site visits to Chicago, Winston-Salem, Columbus, and New York which led the project team to be more efficient in accomplishing the purposes of the preliminary visit. The change, also, was consistent with economy measures dictated by increased travel costs.

Site Visits

Intensive data-collection trips to each of the five funded sites followed the completion of the comparative statutory analysis. The authors worked in Los Angeles for two weeks in February 1982.

During the two weeks 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 California statutes and case law and identified questions of particular theoretical or practical concern for the Los Angeles system.

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 few exceptions, all interviews were conducted by both authors. 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. The people who were interviewed in Los Angeles are named in the "Acknowledgments" section at the beginning of this volume. The site visit began with interviews with judges and observations of hearings. The next interviews tended to be with attorneys, public defenders, deputy district attorneys, and private attorneys. Middle and later interviews tended to focus more on the mental health community: hospital administrators, mental health professionals, and patient advocates.

Court hearings conducted during the time of the visit were observed. For each site, an observation guide was prepared and studied in advance of the hearings. The project team took notes during the hearings. Notes taken during interviews and court hearings were in rough 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, 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 with whom interviews were conducted were not a statistically representative sample in any sense. They were purposively chosen because they were identified as some of the most well-informed and influential people in Los Angeles County with regard to civil commitment from the perspective of court action (see "Perspective," Chapter I). This was consistent with the project goal; that is, 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 by the actions of the court and its allied agencies, from the perspectives of people with extraordinary and authoritative abilities to understand and comment on it.

Of course, the purposive sampling of interviewees within a perspective favoring court action (as opposed to the perspective of a public defender, civil libertarian, or involuntary commitment "abolitionist," for example) may have left some perspectives under-represented. Although we did interview ex-patients and patient advocates, we did not, for one example, speak with patients involuntarily hospitalized at the time of our study. We acknowledge that the perspective of the involuntarily hospitalized persons may be one quite different than that of the ex-patients and advocates to whom we spoke in the various sites, and one potentially valuable for improvement of the system (even from our perspective of court action). The close tracking and observation of several cases through the various stages of the commitment process, enriched by the accounts of the patients themselves is a particularly attractive inquiry which we were, unfortunately, unable to reach. Such omissions do not make the present work less valid, but only incomplete--an unfortunate flaw of most social research.

The Form of the Data

The ultimate goal for this research project was to generate information by 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. 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 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.

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.

Copies of data collection and observation guides as well as a complete set of field notes, with all names and personal identifiers removed, is available from the Institute on Mental Disability and the Law. 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 particular 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, consistent with the project's perspective (see "Perspective," Chapter I) were used to evaluate the civil commitment system described 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 the project team, based upon their knowledge of the literature, observations, discussions with practitioners, and (as our sociologist colleagues are quick to point out) their sociohistorical biographies. 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 discussed, 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 some people some of the time, an assumption consistent with the public values reflected in current commitment laws throughout the country. 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, including fiscal factors, 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, eliminating any unnecessary delays in legal and medical decisionmaking, and avoiding undue burdens on already strained state resources.

These 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. (cf. "Perspective," Chapter I).

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 the beginning of this report. The recommendations should not be taken as research conclusions or empirically proven statements of fact. Rather, they are our suggestions, based upon our studies and points of view. The recommendations derive from a variety of sources: suggestions made by people in Los Angeles County; 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 Los Angeles County to possible solutions. Although it is easy for us to identify a problem, we do not pretend to hold "The Answer." A more realistic expectation is to present "an answer," however modest and tentative, as a stimulus and starting point for thoughtful consideration by those who know the system in Los Angeles 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." This report was sent for review 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.

These reviews were taken into account in preparing the final report. It should not be inferred, however, that this report or its recommendations have been or will be adopted officially by any individual, group, or organization in Columbus, or that the reviewers and participants had a unanimous concurrence of opinion on all the issues raised in this volume. Thus, although the review comments have been incorporated into this report, the text in its revised form should not be taken as a consensual statement or endorsement.

APPENDIX B

PROBABLE CAUSE HEARINGS IN COLUMBUS, OHIO*

Ohio law provides the individual sought to be involuntarily committed with opportunities to test the allegation in the affidavit and the validity of protracted compulsory hospitalization in three separate Probate Court hearings: probable cause, full, and continued commitment hearings. Probable cause hearings are held only upon request of the respondent or his or her counsel (5122.141); however, they are held automatically three days after the filing of an affidavit as a matter of practice in Columbus. Probable cause hearings tend to be less formal than full hearings, and Ohio's Rules of Civil Procedure are not strictly adhered to in probable cause hearings as a matter of law (5122.141, 5122.06). Also, the burden of proof in these initial judicial hearings is "probable cause," instead of the "clear and convincing" evidence required at the full hearings. Representation of the State's case during probable cause hearings need not be by an attorney according to Ohio law (5122.06), and, in Columbus, is usually a hospital social worker. Otherwise, as one attorney put it, the probable cause hearings in Columbus are "carbon copies" of the full hearings.

Full hearings are conducted in a manner consistent with due process of law and the Ohio Rules of Civil Procedure (5122.15). Full hearings must be held sometime between the thirtieth and forty-fifth day after the initial detention of the respondent unless a probable cause hearing was held in this period of time, in which case full hearings must be held within ten days from the probable cause hearing (5122.141). The rule of practice in Columbus is for full hearings to be held within ten days of the probable cause hearing, which always is held within three days of the filing of an affidavit. Continuances are infrequent.

If there has been no disposition of the case after ninety days of involuntary civil commitment of the respondent, either by discharge or a conversion to voluntary hospitalization, a judicial review hearing of continued commitment is held as a matter of law and practice in Columbus (5122.15). If the outcome of the review hearing is continued commitment, review hearings are mandatory every two years thereafter or they may be requested by a respondent every 180 days (5122.15). Only the probable cause hearing and the full hearing will be considered in this chapter. The continued commitment review hearing will be discussed in Chapter VII.

Involuntary civil commitment hearings of mental health cases in Columbus not involving criminal charges are held on Monday, Wednesday,

---

*Excerpted from: Involuntary Civil Commitment in Columbus, Ohio. Williamsburg, Virginia: National Center for State Courts, April 1982, pp. 73-77, 84-86.

and Friday of each week in the Central Ohio Psychiatric Hospital. The hearings commence at approximately 9:30 a.m. in a basement room set aside for hearing mental health cases. The "court room" is approximately 20 x 30 feet in size, and has several windows and two doors, one opening to the basement hallways of the hospital, the other opening to an adjoining room, with a locking door, used as a waiting room for respondents whose cases are close to being heard. At the time of our observation, the basement courtroom was hot, stuffy, and generally uncomfortable; the acoustics in the room did not seem particularly good, although those individuals participating in the cases did not seem to be hindered.

A Referee (an attorney appointed by the Probate Court to hear involuntary civil commitment cases), a court bailiff, a court stenographer, two mental health examiners (psychiatrists), as well as an attorney representing the respondent participate in the hearings. Depending upon whether the hearing is to determine probable cause or a full hearing, the State is represented by a social worker designated by the hospital or by an attorney appointed by the Attorney General's Office.

Probable cause hearings in involuntary civil commitment cases in Franklin County are held promptly and reliably within three "court days" (i.e., weekdays, except holidays) from the filing of an affidavit with the probate court. These preliminary hearings are mandated by Ohio law upon request by the respondent, his or her guardian or counsel, the head of the hospital, or on the court's own motion (5122.141). The Franklin County probate court provides a probable cause hearing automatically as a matter of practice on the assumption that competent counsel always would request such procedural safeguards pursuant to the provisions of law that make them available (5122.141, 5122.05). This automatic provision of probable cause hearings is the topic of considerable debate and cause of dissatisfaction among many persons involved in the involuntary civil commitment process in Franklin County. Based upon concerns for economy and efficiency, the vast majority of attorneys, referees, and mental health personnel with whom we communicated over the course of our study called for the abolition of automatic probable cause hearings, or their provision in a modified form. A vocal minority of those we interviewed favor the retention of the current automatic provision of this hearing.

Arguments for Automatic Probable Cause Hearings

The issue of the right to a probable cause hearing in involuntary civil commitment proceedings has been addressed by a number of federal and state courts. A majority of these courts implicitly acknowledge the desirability of a probable cause hearing before the respondent is taken into custody and involuntarily hospitalized, but grapple primarily with arguments for and against a probable cause hearing after the respondent has already been taken to the hospital against his or her will. This acknowledgement of an ideal tempered with the realization of practice is reflected in Ohio law. That is, Ohio statute requires that "[w]here possible, the probable cause hearing shall be held before the respondent is taken into custody" (5122.141, emphasis added). Implicit in this language seems to be the acknowledgement that, as a

practical matter, probable cause hearings rarely, if ever, would be held before a respondent is taken into custody. The issue, thus, turns on the question of how long a person may be involuntarily detained prior to the hearing on probable cause.

Certainly, reducing the deprivation of a respondent's liberty prior to a hearing on probable cause is the most forceful reason for providing a prompt probable cause hearing in civil commitment proceedings. It also is the strongest argument we heard for automatic probable cause hearings in Franklin County. One attorney, acknowledging the expense of conducting probable cause hearings in light of the fact that in the vast majority of cases the disposition of the case is the same, whether or not a probable cause hearing would be held, nonetheless argued strongly that the price paid is worth the check against a "massive curtailment of liberty." This attorney felt that probable cause hearings should be continued to be held three days following the filing of an affidavit, even if it were to be supplanted by a full hearing within five court days of the original involuntary hospitalization, and even if only one out of a hundred respondents were released at the probable cause hearing. In short, five days (or, to be more exact, the additional two days beyond the three days of hospitalization before probable cause hearing) of forced hospitalization without judicial review constitutes an intolerable deprivation of liberty to be avoided if at all possible, in the opinion of this attorney. Although we take issue with this argument later in this chapter, it is a strong argument not easily dismissed.

Another attorney suggested that probable cause hearings contribute to the election of voluntary hospitalizations. This attorney suggested that probable cause hearings provide an opportunity to hear medical testimony in an adversary proceeding contributing, according to his experiences, to respondents' more frequent acknowledgements of their mental disorder. "When I interview a respondent prior to a probable cause hearing," he stated, "he or she is usually reluctant to sign an application for voluntary admission. However, once psychiatric testimony has been heard, many times that same respondent is then willing to voluntarily enter the hospital prior to the commencement of the full hearing." He concluded that the "elimination of the probable cause hearing will reduce the number of voluntary applications. More respondents will be judicially hospitalized who might otherwise become voluntary patients."

Still another attorney argued for the retention of the automatic probable cause hearing on other grounds: it provided the mechanism for the expungement of all records of the involuntary civil commitment proceedings if the court did not find probable cause to believe that the respondent is a mentally ill person subject to hospitalization by court order (5122.141). Apparently, the Franklin County Probate Court has interpreted the Ohio statutes to mean that expungement cannot be ordered after probable cause has been determined, even if the respondent is released at the full hearing due to the Court's failure to find "clear and convincing" evidence. Although there are no statutory provisions for expungement after a finding of probable cause, the expungement of all

records of involuntary civil commitment proceedings following discharge or release of a respondent from a hospital, regardless of how long the hospital stay, does not seem contrary to any of the provisions in Chapter 5122 of the Ohio Revised Code. The Franklin County Probate Court's procedure of rehearing probable cause for the purpose of expungement when a respondent elects voluntary admission, or is released between the probable cause hearing and the full hearing, may be applicable as well to cases of respondents dismissed at the full hearing, or discharged from the hospital sometime after the full hearing.

Another attorney suggested that there may be monetary incentives for appointed attorneys' support of the retention of the automatic probable cause hearing. That is, because attorneys are paid per hearing, the elimination of probable cause hearings would cut deeply into their compensation.

Arguments Against Automatic Probable Cause Hearings

The majority of the individuals we interviewed in Columbus--referees, attorneys, and mental health personnel alike--are in favor of discontinuing the practice in Franklin County of providing automatic probable cause hearings in commitment cases. One psychiatrist (who, interestingly, represented the mental health community at the time that the probable cause provision was written into law in Ohio), expressed the attitude of the majority. He had initially hoped that the probable cause hearing would be a quick, easy, and inexpensive procedure that would, nonetheless, provide safeguards for the protection of respondent's liberty interests. He bemoaned the fact that the procedure had become the extremely complicated and expensive procedure it is in Franklin County. Although the probable cause hearing seems to have evolved in its present form out of a legitimate concern for safeguarding the legal rights of the respondent, few in Columbus appear to be happy with it in its present form.

In addition to the arguments based on concerns for economy, which were voiced by those we interviewed, various other arguments against automatic probable cause hearings, not necessarily consistent with each other, were offered:

- A survey conducted in June 1981 by the Probate Court of 100 involuntary civil commitment cases in Franklin County found that only 2 (2%) of the cases were dismissed at the probable cause stage.

- Given the effectiveness of the prehearing screening mechanism, the investigation of the affidavit, and the ex parte review of the affidavit and determination of probable cause (see Chapter III), the probable cause hearing has become no more than an expensive "rubber stamp" of the court's acceptance of the affidavit and issuance of a temporary order of detention.

- The full hearing, typically held one week after the probable cause hearing, is essentially a "carbon copy" of the probable cause hearing. Attorneys representing the respondents usually do not offer new evidence, present new witnesses, nor pose new questions for the expert witnesses to answer which might enable the Court to make a more informed decision at the full hearing.

- A record of prior hospitalization of the respondent constitutes, as a matter of practice, prima facie evidence meeting the low burden of proof for a probable cause finding, though it does not constitute the "clear and convincing evidence" required at the full hearing. In such cases, the probable cause hearing seems ritualistic and pointless.

- It is the policy of Harding Hospital to administer no treatment to involuntarily hospitalized persons until after a full hearing in the case. Thus, in at least one hospital, involuntary hospitalization before a full judicial hearing, whether interrupted by a probable cause hearing or not, constitutes the equivalent of preventive detention without treatment, until such time as the Court finds clear and convincing reasons for compulsory hospitalization.

- Although the probable cause hearings are conducted in general accordance with due process standards, the inability to subpoena witnesses (especially the affiant), frustrates the respondent attorney's abilities to test the allegations in the affidavit effectively, thereby making the probable cause hearing relatively ineffective. (This problem, it should be noted, is one that can be remedied without the elimination of the automatic probable cause hearing, and thus is not a strong argument.)

Many of the interviewees in Columbus who offered arguments against the automatic conduct of probable cause hearings in commitment cases suggested that, if this preliminary hearing were eliminated, the full hearing should be held sooner than it is now, i.e., within five or seven days of the filing of an affidavit. One referee suggested that the probable cause hearing could be eliminated only if the current prescreening and diversion procedures could be maintained at the highest levels of efficiency and effectiveness.

CONCLUSIONS AND RECOMMENDATIONS

The vast majority of those we interviewed in Columbus felt that the practice in Franklin County of providing automatic probable cause hearings to all respondents in involuntary civil commitment proceedings did not sufficiently serve the liberty interests of respondents to outweigh the interests of efficiency and economy. With a change in the

timing of the full hearing, a strengthening of the prescreening procedures, a meaningful investigation and review of the affidavit, and an allowance for the expungement of records upon dismissal of the case at full hearing, the automatic conduct of a probable cause hearing in every commitment case is unwarranted.

RECOMMENDATION: THE PRACTICE OF PROVIDING AUTOMATIC PROBABLE CAUSE HEARINGS IN FRANKLIN COUNTY SHOULD BE ELIMINATED.

This recommendation, arguably, takes from the respondent an opportunity to promptly test the allegations of the affidavit and eliminates a safeguard against improper compulsory hospitalization. Obviously, a replacement for this safeguard and the strengthening of other protections would make this recommendation more palatable. The following two recommendations and the discussion following them speak to this point.

RECOMMENDATION: FULL HEARINGS IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS IN FRANKLIN COUNTY SHOULD BE HELD WITHIN FIVE DAYS OF THE FILING OF AN AFFIDAVIT.

RECOMMENDATION: PROCEDURES FOR PRESCREENING AND DIVERSION BY THE COMMUNITY MENTAL HEALTH CENTERS, INVESTIGATION OF THE AFFIDAVIT, REVIEW BY, AND THE EX PARTE DETERMINATION OF PROBABLE CAUSE BY THE REFEREE SHOULD BE ENHANCED AND STRENGTHENED.

In making the recommendation to postpone the judicial review of the validity of compulsory hospitalization, even from three days to five days, we acknowledge that the arguments for these recommendations may be difficult to swallow. In the abstract, few of us would place economy, efficiency, and expediency above liberty. Once we have set in our minds, however arbitrarily, the deprivation of liberty that can be justified without a judicial review, it is difficult to retreat from that stand in making the above recommendations. We openly acknowledge this potential dilemma. We note, however, that the provision of a full hearing five days after the filing of an affidavit, as recommended, is consistent with procedures in other jurisdictions throughout the country.

With the elimination of an automatic probable cause hearing within three days and the provision of a full hearing within five, are there compensating factors that may justify the additional two days of involuntary hospitalization? The strengthening of the pre-hearing screening and review, one could argue, casts a finer net through which few cases of improper detention and hospitalization pass. The great majority of involuntary civil commitment cases that are initiated with a contact with the probate court are screened and diverted by the prescreening process to community placements. Further, assuming a careful scrutiny of the affidavit by the deputy clerk at the time of filing, and a thorough ex parte review and determination of probable cause by the "in-house" referee, another check of the validity of

compulsory hospitalization is provided. Finally, the additional two days before a hearing is held may enable the counsel for the respondent to better prepare for the case, thereby reducing the chances of commitment at the five-day hearing.

The elimination of the automatic provision of probable cause hearings in Franklin County may be somewhat problematic due to the reasoning upon which the procedure is based. It is assumed that competent counsel would always request a probable cause hearing if permitted by statute. How then can the court cease providing automatic probable cause hearings and discourage attorneys, who are well aware of the assumptions upon which the automatic provision is based, from always requesting probable cause hearings? To avoid the assumption of negligence by counsel when a probable cause hearing is not requested, it might be suggested that counsel take pains in explaining to respondents their right to a probable cause hearing upon request. If in the judgment of the counsel, the respondent does not wish to pursue this right and the attorney considers that the preliminary hearing would provide few benefits to the respondent's case, counsel need not request a hearing. Failure to request a probable cause hearing would be considered negligent only if the respondent's attorney did not fully explain the right to such a hearing to the respondent, or failed to request such a hearing upon the express wishes of the respondent.

The final consideration in this concluding section concerns the expungement of records of involuntary civil commitment proceedings. As discussed earlier, it is standard practice for the Court to order the expungement of all records following the failure to find probable cause; yet, once a full hearing is initiated, the court will not order the expungement of records even if the respondent is dismissed at the hearing. The reasoning upon which this restriction of expungement is apparently based is that if the evidence is insufficient for a finding of probable cause, the expungement of records is justified; however, if the evidence is sufficient for such a finding, but not quite "clear and convincing," the Court considers this middle ground between probable cause and "clear and convincing" evidence sufficient to justify maintaining the records.

RECOMMENDATION: THE EXPUNGEMENT OF ALL RECORDS OF INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS SHOULD BE MADE POSSIBLE, UPON ORDER OF THE COURT, WHEN A RESPONDENT IS DISCHARGED AT A FULL HEARING.

This recommendation is not based on any knowledge of compelling state interests in maintaining records of involuntary civil commitment hearings, or suggestions for guidelines for the court in ordering expungement of records. It is offered, simply, to lift an impediment to the elimination of the conduct of automatic probable cause hearings.