Provisional Substantive and Procedural Guidelines for Involuntary Civil Commitment

Involuntary Civil Commitment Project
Institute on Mental Disability and the Law
National Center for State Courts

July 1982

These Provisional Guidelines and the project upon which they are based were made possible by a grant from
The John D. and Catherine T. MacArthur Foundation

INVOLUNTARY CIVIL COMMITMENT PROJECT
INSTITUTE ON MENTAL DISABILITY AND THE LAW
NATIONAL CENTER FOR STATE COURTS

Project Staff

Ingo Keilitz
Senior Staff Associate and Project Director

Paul Barnett
Project Assistant

W. Lawrence Fitch
Staff Attorney

Janice Hendryx
Senior Staff Associate

Mary Elizabeth Holmstrup
Project Assistant

Richard Van Duizend
Senior Staff Attorney

Bradley D. McGraw
Project Assistant

Dana Patton
Project Secretary

Lisa Russell
Staff Associate

Brenda Taylor
Project Staff

Joel Zimmerman
Associate Director for
Research and Development

Project Advisory Board

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 Court Judge
Fulton County Courthouse
Atlanta, Georgia

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

Joseph Schneider (Chairman)
Circuit Court Judge
Chicago, Illinois

David B. Wexler
Professor
University of Arizona
Tucson, Arizona

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

SUMMARY OF CONTENTS

CONTENTS

PART III

RESPONDENT'S COUNSEL

PART IV

HEARING CHARACTERISTICS

PART V

TREATMENT CONSIDERATIONS
DURING JUDICIAL HEARING

PART VI

POSTHEARING MATTERS

PART VII

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS FOR IMPROVEMENT OF INVOLUNTARY CIVIL COMMITMENT IN FIVE METROPOLITAN AREAS IN THE UNITED STATES

PREFACE AND ACKNOWLEDGMENTS

In January 1981, the National Center for State Courts embarked on a multi-year project aimed at the study and improvement of the involuntary civil commitment process. The project's principal focus has been on the pivotal role of judges, who serve not only as neutral decisionmakers in the courtroom, but also as executives of the courts, which constitute one unit within the complex interorganizational network that comprises the mental health-judicial system. Recognizing that the scholarly debate about how society should handle its mentally ill, helpless, and potentially dangerous individuals, is well over 100 years old, that resolution of the problem hardly seems imminent, and that law and practice are never entirely parallel and sometimes not even consistent, the project emphasizes current procedures and practices of court personnel who participate in involuntary civil commitment proceedings. The goal is to provide practical information to the courts and their allied agencies, based on both theory and practice, to make the involuntary civil commitment process work as fairly and efficiently as it can.

This volume marks the completion of Phase 1 of the Involuntary Civil Commitment Project (ICCP) by the Institute on Mental Disability and the Law of the National Center for State Courts. Phase 1 has been made possible primarily by a grant from the John D. and Catherine T. MacArthur Foundation. Project work on Phase 1 of the Involuntary Civil Commitment Project was begun in January 1981 and ended in July 1982. Phase 1 has resulted in two major products. The first is a set of five reports 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 recommendations are summarized in Part VII of this work. This volume is the second product of Phase 1 of the ICCP. It has a national perspective but builds upon the field work and analyses of involuntary civil commitment undertaken in the five metropolitan areas mentioned above. Together these two products contain over 240 recommendations and guidelines for improvement of the involuntary civil commitment process.

The information generated by the ICCP is intended to be pragmatic and utilitarian. The five volumes focusing on specific areas of the country emphasize the manner in which local commitment systems function or should function. ICCP staff have observed and analyzed how specific statutory provisions are implemented, where and why practice deviates from law, and what practices go beyond the current scope of the law. Strengths and weaknesses have been identified and recommendations made for change and improvement.

The provisional guidelines in this volume also are pragmatically oriented. They are 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 this 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 the ICCP has been planned and will commence in September, 1982, contingent upon receipt of adequate funding. During the second phase, the Institute on Mental Disability and the Law intends to put the provisional guidelines and the site-specific recommendations into the hands of those who can use them. The Phase 2 work will entail five major elements: (1) the review, revision, publication, and dissemination of the provisional guidelines and recommendations developed in Phase 1 of the ICCP; (2) the development of an information clearinghouse for the improvement of involuntary civil commitment; (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.

The guidelines contained in this volume will be provisional until much of the work of Phase 2 has been completed. Readers of this volume and, especially, users of the provisional guidelines are invited to submit their comments. Comments will be considered in revisions and refinements of the provisional guidelines, and in the work of the second phase of the ICCP in general.

The efforts of a great many individuals and organizations have gone into the research, analyses, drafting, reviewing, and editing of this volume. Phase 1 of ICCP has been made possible by grant from the John D. and Catherine T. MacArthur Foundation. Its support is gratefully acknowledged. William T. Kirby, Director of the MacArthur Foundation, deserves thanks for his enormous patience in the face of a project that has required more time and work than initially anticipated. A cooperative funding arrangement among five community foundations made possible the field work in New York, Los Angeles, Columbus, Winston-Salem, and Chicago, upon which many of the provisional guidelines are based. These community foundations are the New York Community Trust, the Columbus Foundation, the Winston-Salem Foundation, the Della Martin Foundation, and the Chicago Community Trust.

The staff, management, and Board of Directors of the National Center for State Courts are acknowledged for their contributions in making the ICCP possible. Edward B. McConnell, Executive Director of the National Center, originated the project concept. 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. The staffs of the word-processing center, the National Center's Publication Department, and the Xeroxing center provided invaluable support that made publication of the volume possible.

In the early stages of Phase 1, project staff received guidance from a remarkably informed group of people known collectively as the National Advisory Board. The individuals in this group made extensive contributions in helping to frame and resolve major issues of substance,

research design, target audiences, and format. The names and affiliations of the members of the ICCP National Advisory Board appear on page iii.

During the field work in New York, Los Angeles, Winston-Salem, Columbus, and Chicago, literally hundreds of individuals helped explain and demonstrate the workings of the involuntary civil commitment systems in those cities. The list of all those who generously gave of their time for interviews, meetings, and reviews of various report drafts, is simply too long to reproduce here. Their help is gratefully acknowledged.

Finally, it is fitting to acknowledge the contribution of the ICCP staff whose names are listed on page iii. They shared the tasks of studying laws, reading mental health law literature, doing field work, analyzing and organizing the enormous descriptive data acquired during the course of the ICCP, and drafting and editing reports. Their work and ideas are melded in this volume. The ultimate responsibility for the final substance of this volume, however, rests with the project director.

Ingo Keilitz
Williamsburg, Virginia
July 1982

SUMMARY OF GUIDELINES

This Summary of Guidelines contains provisional guidelines without commentary. These guidelines are excerpted from Provisional Substantive and Procedural Guidelines for Involuntary Civil Commitment to give the reader an overview. Because, however, this summary presents the guidelines without supporting commentary, it may be misleading. The reader is strongly encouraged to refer to the specific parts of Provisional Substantive and Procedural Guidelines for Involuntary Civil Commitment in which the bases and rationale for each guideline is discussed in detail.

PART II. PREHEARING MATTERS

Initiating Involuntary Civil Commitment

GUIDELINE II-A. (1) REGARDLESS OF THE COMMITMENT ROUTE -- EMERGENCY, JUDICIAL, NON-JUDICIAL, OR GUARDIANSHIP -- ENTRY INTO THE MENTAL HEALTH-JUDICIAL SYSTEM SHOULD BE MONITORED AND REGULATED BY AUTHORIZED "GATEKEEPERS" AT DESIGNATED "PORTALS" IN THE COMMUNITY. THESE GATEKEEPERS SHOULD BE EMPOWERED AND QUALIFIED TO INITIATE INVOLUNTARY CIVIL COMMITMENT ALONG ITS VARIOUS ROUTES OR TO DIVERT CASES TO LESS RESTRICTIVE ALTERNATIVES.

(2) COMMUNITY PORTALS, SERVING AS SCREENING AGENCIES WITHIN THE COMMUNITY, SHOULD REVIEW AND INVESTIGATE APPLICATIONS FOR INVOLUNTARY COMMITMENT, AND, IF APPROPRIATE, SHOULD DIVERT CASES TO LESS RESTRICTIVE TREATMENT ALTERNATIVES (AS PRESCRIBED IN GUIDELINES II-S THROUGH II-U). SCREENING REPORTS SHOULD BE FILED WITH THE COURT.

GUIDELINE II-B. JUDGES, COURT ADMINISTRATORS, AND COURT MANAGERS SHOULD INFLUENCE THE POLICIES OF PORTAL AGENCIES (E.G., POLICE DEPARTMENTS, SHERIFF'S DEPARTMENTS, MENTAL HEALTH DEPARTMENTS, COMMUNITY MENTAL HEALTH AGENCIES, AND HOSPITALS) TO FOSTER A UNIFORM, UNDERSTANDABLE, AND CONTROLLABLE PROCEDURE FOR INITIATING AND SCREENING INVOLUNTARY COMMITMENT CASES.

GUIDELINE II-C. THE COURT SHOULD REVIEW, MONITOR, AND REGULATE, THE ACCESS TO THE MENTAL HEALTH-JUDICIAL SYSTEM BY THE VARIOUS INVOLUNTARY CIVIL COMMITMENT ROUTES.

GUIDELINE II-D. JUDGES AND ATTORNEYS SHOULD BE THOROUGHLY FAMILIAR WITH THE METHODS AND OPERATIONS OF THE COMMUNITY PORTALS AND GATEKEEPERS REGULATING INVOLUNTARY CIVIL COMMITMENT CASES.

GUIDELINE II-E. (1) GATEKEEPERS SHOULD BE MENTAL HEALTH PROFESSIONALS, OR COURT PERSONNEL WORKING IN COOPERATION WITH MENTAL HEALTH PROFESSIONALS, EXPERIENCED IN THE DIAGNOSIS OF MENTAL ILLNESS AND FACILE IN APPLYING THE LEGAL, PSYCHOLOGICAL, AND SOCIAL CONSTRUCTS USED IN MAKING DECISIONS CONCERNING DETENTION PURSUANT TO INVOLUNTARY HOSPITALIZATION, RELEASE, AND ALL INTERMEDIATE ALTERNATIVES.

(2) GATEKEEPERS SHALL SERVE AS SCREENERS, OR WORK IN CLOSE COOPERATION WITH SCREENERS, TO CAUSE REVIEW AND INVESTIGATION OF COMMITMENT APPLICATIONS, AND THE SCREENING AND DIVERSION OF CASES FROM COMPULSORY HOSPITALIZATION AS DESCRIBED IN GUIDELINES II-S THROUGH II-U.

GUIDELINE II-F. GATEKEEPERS SHOULD HAVE THE AUTHORITY TO ORDER INVOLUNTARY DETENTION AND TO REQUEST AMBULANCE OR POLICE ASSISTANCE FOR TRANSPORTING RESPONDENTS TO AND FROM APPROPRIATE MENTAL HEALTH FACILITIES.

Custody and Detention

GUIDELINE II-G. THE GROUNDS USED BY LAW ENFORCEMENT OFFICIALS FOR TAKING CUSTODY OF A RESPONDENT IN EMERGENCY CIRCUMSTANCES MAY BE DIFFERENT FROM THE GROUNDS PRESCRIBED IN STATUTE FOR DETENTION PURSUANT TO INVOLUNTARY COMMITMENT. LAW ENFORCEMENT OFFICIALS SHOULD USE A COMMON SENSE MODEL OF MENTAL ILLNESS, BUILT ON EXPERIENCE, AND ON THRESHOLDS OF DANGEROUSNESS AND DISABILITY DIFFERENT THAN THOSE WHICH PRACTITIONERS IN THE MENTAL HEALTH-JUDICIAL SYSTEM FOLLOW PURSUANT TO MENTAL HEALTH LAWS.

GUIDELINE II-H. THE GROUNDS WHICH GATEKEEPERS USE FOR INVOLUNTARY DETENTION IN A MENTAL HEALTH FACILITY SHOULD BE BASED ON THE PSYCHOLEGAL CRITERIA PRESCRIBED IN STATUTE.

GUIDELINE II-I. (1) PROCEDURES FOR INITIATING INVOLUNTARY CIVIL COMMITMENT THROUGH COMMUNITY PORTALS AND BY MEANS OF GATEKEEPERS SHOULD NOT BE UNDULY TIME-CONSUMING OR BURDENSOME TO LAW ENFORCEMENT OFFICIALS WHO TAKE INITIAL CUSTODY OF RESPONDENTS.

(2) CUSTODY-TAKING PEACE OFFICERS SHOULD NEED TO WORK ONLY WITH A LIMITED NUMBER OF COMMUNITY PORTALS AND GATEKEEPERS TO EFFECT TRANSFER OF RESPONSIBILITY FOR A RESPONDENT PURSUANT TO INVOLUNTARY CIVIL COMMITMENT.

(3) ALTHOUGH IT MAY BE VERY IMPORTANT FOR ADMITTING FACILITY STAFF TO SPEAK WITH THE CUSTODY-TAKING OFFICER, PEACE OFFICERS SHOULD NOT BE REQUIRED TO REMAIN WITH A RESPONDENT TO AWAIT THE RESULTS OF MENTAL HEALTH EXAMINATIONS.

(4) IF A RESPONDENT IS RELEASED AFTER MENTAL HEALTH EXAMINATION, LAW ENFORCEMENT AGENCIES SHOULD NOT BE RESPONSIBLE FOR RETURNING THE RESPONDENT TO THE PLACE OF CUSTODY-TAKING.

GUIDELINE II-J. IN RECOGNITION THAT RESPONDENTS FACING INVOLUNTARY CIVIL COMMITMENT ARE ONLY ALLEGED TO BE MENTALLY DISTURBED AND HAVE NOT BEEN CHARGED WITH COMMISSION OF CRIMINAL ACTS, THEIR APPREHENSION AND CUSTODY-TAKING SHOULD BE IN THE MANNER LEAST CONSPICUOUS, AND LEAST DISRUPTIVE TO THE RESPONDENT'S LIFE. CUSTODY-TAKING PEACE OFFICERS MUST MAKE EVERY ATTEMPT TO SAFEGUARD THE RESPONDENT'S PERSONAL PROPERTY.

GUIDELINE II-K. COURTS SHOULD ENCOURAGE POLICE DEPARTMENTS TO DEVELOP SPECIAL MENTAL HEALTH UNITS, CAPABLE OF 24-HOUR, RAPID-RESPONSE CRISIS INTERVENTION. SUCH UNITS SHOULD WORK CLOSELY AND COOPERATIVELY WITH COMMUNITY MENTAL HEALTH-JUDICIAL SYSTEM GATEKEEPERS.

GUIDELINE II-L. TRAINING SHOULD BE AVAILABLE FOR LAW ENFORCEMENT AGENCIES CONCERNING: THE NATURE AND MANIFESTATIONS OF MENTAL HEALTH DISORDERS, HOW TO COMMUNICATE WITH AND HANDLE MENTALLY DISORDERED INDIVIDUALS AND, IMPORTANTLY, COMMUNITY RESOURCES AND PORTALS TO WHICH ALLEGEDLY MENTALLY ILL INDIVIDUALS MAY BE TAKEN OR REFERRED PURSUANT TO INVOLUNTARY HOSPITALIZATION OR SOME LESS RESTRICTIVE ALTERNATIVE.

GUIDELINE II-M. (1) THE PERSON TAKING A RESPONDENT INTO CUSTODY, SHOULD GIVE THE RESPONDENT THE FOLLOWING INFORMATION: (a) THE NAME, PROFESSIONAL DESIGNATION, AND AGENCY AFFILITATION OF THE PERSON TAKING CUSTODY; (b) THE NATURE AND CONSEQUENCES OF THE CUSTODY-TAKING, INCLUDING THAT IT IS NOT A CRIMINAL ARREST; (c) THAT THE PERSON IS GOING TO BE TRANSPORTED BY PARTICULAR MEANS (E.G., AMBULANCE, POLICE CRUISER, PERSONAL CAR) FOR INVOLUNTARY EXAMINATION, TREATMENT, OR CARE, BY MENTAL HEALTH PROFESSIONALS AT A MENTAL HEALTH FACILITY IDENTIFIED BY NAME; (d) THAT LEGAL RIGHTS WILL BE EXPLAINED BY THE GATEKEEPER AT THE MENTAL HEALTH FACILITY TO WHICH THE PERSON IS TAKEN; AND, (e) IF THE PERSON IS TAKEN INTO CUSTODY NEAR HIS OR HER RESIDENCE, THAT HE OR SHE MAY BRING ALONG A FEW PERSONAL ITEMS, MAKE ONE TELEPHONE CALL, AND LEAVE APPROPRIATE MESSAGES FOR FRIENDS OR FAMILY MEMBERS.

(2) THE AUTHORIZED PERSON SHOULD GIVE THE INFORMATION IN (1) ORALLY. IN ADDITION TO INFORMING THE RESPONDENT THAT HIS OR HER LEGAL RIGHTS WILL BE EXPLAINED BY GATEKEEPERS, THE AUTHORIZED PERSON SHOULD GIVE THE RESPONDENT, AT THE TIME OF CUSTODY-TAKING, WRITTEN NOTICE OF HIS OR HER LEGAL RIGHTS.

(3) ORAL AND WRITTEN STATEMENTS REGARDING LEGAL RIGHTS, PROTECTIONS, AND EXPLANATIONS OF PROCEDURES, PROVIDED TO EACH RESPONDENT AT THE TIME OF CUSTODY-TAKING, SHOULD BE IN SIMPLE LANGUAGE.

GUIDELINE II-N. COMMUNITY PORTALS AND APPROPRIATE PLACES FOR PREHEARING DETENTION SHOULD BE CLEARLY IDENTIFIED, AND DUTIES AND AUTHORITIES SHOULD BE DELINEATED. THIS INFORMATION SHOULD BE DISSEMINATED TO LAW ENFORCEMENT OFFICIALS, COURT PERSONNEL, GATEKEEPERS, AND OTHER OFFICIALS IN THE MENTAL HEALTH-JUDICIAL SYSTEM.

GUIDELINE II-O. THE COURT SHOULD ENSURE THAT PROMPT NOTICE OF A PERSON'S DETENTION PURSUANT TO INVOLUNTARY COMMITMENT IS GIVEN TO APPROPRIATE INDIVIDUALS AND AGENCIES.

Review of Allegations and Screening of Cases Before Detention

GUIDELINE II-P. (1) REGARDLESS OF THE COMMITMENT ROUTE, AUTHORIZATION TO INITIATE COMMITMENT PROCEEDINGS SHOULD ALWAYS BE BASED ON A WRITTEN APPLICATION COMPLETED AND FILED WITH DESIGNATED COMMUNITY PORTALS BEFORE A PERSON IS TAKEN INTO CUSTODY AND DETAINED PURSUANT TO INVOLUNTARY CIVIL COMMITMENT.

(2) BEFORE A WRITTEN APPLICATION CAN BE FILED, AND BEFORE SCREENING OF THE CASE AS DESCRIBED IN GUIDELINE II-S, IF A GATEKEEPER DETERMINES THAT IMMEDIATE DETENTION AND HOSPITALIZATION IS NECESSARY TO PREVENT SERIOUS BODILY HARM TO THE RESPONDENT OR OTHERS, SUCH AN APPLICATION MAY BE FILED WITH A DESIGNATED PORTAL WITHIN 24 HOURS OF THE RESPONDENT'S ADMISSION TO A MENTAL HEALTH FACILITY. IN SUCH EMERGENCY CIRCUMSTANCES, THE ADMITTING FACILITY SHOULD TRANSMIT THE APPLICATION, AND THE COMMUNITY PORTAL SHOULD BE RESPONSIBLE FOR SCREENING.

GUIDELINE II-Q. A WRITTEN APPLICATION FOR INVOLUNTARY CIVIL COMMITMENT MUST ALLEGE THAT A RESPONDENT SHOULD BE SUBJECT TO COMPULSORY HOSPITALIZATION. IT SHOULD SPECIFY THE FACTUAL INFORMATION ON WHICH ALLEGATIONS ARE BASED INCLUDING: (a) A DESCRIPTION OF OVERT ACTS,

SPECIFIC THREATS, OR SPECIFIC CIRCUMSTANCES, INDICATING THAT THE RESPONDENT IS A LIKELY CANDIDATE FOR INVOLUNTARY COMMITMENT; (b) PERSONAL INFORMATION ABOUT THE RESPONDENT INCLUDING HIS OR HER PRESENT LOCATION, PERMANENT RESIDENCE, AGE, PHYSICAL DESCRIPTION, EDUCATION, FINANCIAL CONDITION, FAMILY HISTORY, AND HISTORY OF MENTAL AND PHYSICAL ILLNESSES AND PREVIOUS HOSPITALIZATIONS; (c) NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF FAMILY MEMBERS AND ACQUAINTANCES OF THE RESPONDENT, AND ALL PERSONS KNOWN TO THE APPLICANT WHO HAVE KNOWLEDGE OF SUCH FACTUAL INFORMATION THROUGH PERSONAL OBSERVATION.

GUIDELINE II-R. APPLICATIONS TO GATEKEEPERS SHOULD BE READILY AVAILABLE AT DESIGNATED PORTALS AND MAY BE EXECUTED BY ANY ADULT PERSON WITH THE ASSISTANCE OF GATEKEEPERS. A SINGLE PREPRINTED FORM SHOULD BE USED FOR ALL COMMITMENT APPLICATIONS, REGARDLESS OF THE ROUTE TAKEN.

GUIDELINE II-S. WHEN A COMMUNITY PORTAL RECEIVES A REQUEST FOR AN APPLICATION FOR INVOLUNTARY COMMITMENT, A GATEKEEPER SHALL: (a) IMMEDIATELY DETERMINE WHETHER TO PURSUE COMMITMENT PROCEEDINGS, OR TO ADVISE THE APPLICANT TO SEEK ALTERNATIVES TO COMPULSORY HOSPITALIZATION; (b) IF SUCH ALTERNATIVES ARE NOT PURSUED BY THE APPLICANT, ASSIST THE APPLICANT IN COMPLETING THE APPLICATION FOR INVOLUNTARY COMMITMENT; AND, (c) PREPARE FOR A REVIEW AND INVESTIGATION, OF THE APPLICATION, AND SCREENING OF THE CASE.

GUIDELINE II-T. (1) WHEN A COMMUNITY PORTAL RECEIVES AN APPLICATION, AND A GATEKEEPER DETERMINES THAT INVOLUNTARY COMMITMENT PROCEEDINGS SHOULD BE INITIATED PURSUANT TO GUIDELINE II-S, PARAGRAPH (a), THE GATEKEEPER SHALL CAUSE AN INVESTIGATION AND REVIEW OF THE APPLICATION, AND POSSIBLE SCREENING AND DIVERSION OF THE RESPONDENT FROM COMPULSORY HOSPITALIZATION, TO BE COMPLETED BY THE END OF THE SECOND DAY AFTER RECEIPT OF THE APPLICATION.

(2) INVESTIGATION AND REVIEW OF THE APPLICATION SHALL INCLUDE THE FOLLOWING: (a) REVIEW AND ASSESSMENT OF THE RELIABILITY AND CREDIBILITY OF ALL FACTUAL INFORMATION CONTAINED IN THE WRITTEN APPLICATION AS PRESCRIBED IN GUIDELINE II-Q, PARAGRAPHS (a) THROUGH (c); AND, (b) INTERVIEWS OF THE APPLICANT AND AVAILABLE WITNESSES WHO HAVE KNOWLEDGE OF THE RESPONDENT THROUGH PERSONAL INFORMATION.

(3) SCREENING SHALL INCLUDE A PERSONAL INTERVIEW WITH THE RESPONDENT WHEREUPON A DETERMINATION IS MADE TO PURSUE INVOLUNTARY CIVIL COMMITMENT OR TO DIVERT THE RESPONDENT TO LESS RESTRICTIVE TREATMENT AND CARE.

THE INTERVIEW SHALL BE CONDUCTED AT A COMMUNITY PORTAL AT A SPECIFIC TIME AND DATE OR, IF THE RESPONDENT IS UNWILLING OR UNABLE TO COME TO THE PORTAL, AT THE RESIDENCE OR OTHER LOCATION OF THE RESPONDENT OR, IF A PERSONAL FACE-TO-FACE INTERVIEW CANNOT BE ARRANGED WITHIN THE PRESCRIBED TIME LIMITS, THE INTERVIEW MAY BE CONDUCTED BY TELEPHONE. THE INTERVIEW SHALL INCLUDE: (a) GIVING THE RESPONDENT A COPY OF THE COMPLETED APPLICATION AND AN ORAL EXPLANATION OF THE NATURE, PURPOSE, AND POSSIBLE CONSEQUENCES OF THE INTERVIEW; (b) WRITTEN NOTICE AND ORAL EXPLANATION OF ALL RIGHTS PRESCRIBED BY LAW, AND AN OFFER OF ASSISTANCE TO THE RESPONDENT TO REALIZE THOSE RIGHTS; AND, (c) MENTAL HEALTH SERVICES SUCH AS CRISIS INTERVENTION, COUNSELING, MENTAL HEALTH THERAPY, AND OTHER PSYCHIATRIC, WELFARE, PSYCHOLOGICAL, AND LEGAL SERVICES AIMED AT AVOIDING UNNECESSARY AND INAPPROPRIATE COMPULSORY HOSPITALIZATION AND PROVIDING CARE AND TREATMENT IN THE LEAST RESTRICTIVE SETTING.

GUIDELINE II-U. (1) AT THE COMPLETION OF THE INVESTIGATION, REVIEW, AND SCREENING, THE GATEKEEPER SHALL DETERMINE WHETHER TO PURSUE COMMITMENT PROCEEDINGS, TO DIVERT THE CASE TO SOME ALTERNATIVE TREATMENT OR CARE, OR TO TERMINATE ANY FURTHER ACTIONS IN THE CASE.

(2) IF THE GATEKEEPER DETERMINES THAT THE RESPONDENT MEETS THE COMMITMENT CRITERIA AND THAT THE RESPONDENT CANNOT BE SERVED IN A SETTING LESS RESTRICTIVE THAN THAT PROVIDED BY COMPULSORY HOSPITALIZATION WITHOUT GIVING RISE TO IMMEDIATE AND SUBSTANTIAL RISKS TO THE RESPONDENT OR OTHERS, THE GATEKEEPER SHOULD CAUSE THE RESPONDENT TO BE TAKEN TO A MENTAL HEALTH FACILITY PURSUANT TO INVOLUNTARY COMMITMENT.

GUIDELINE II-V. (1) THE GATEKEEPER SHALL CAUSE A REPORT OF THE REVIEW, INVESTIGATION, AND SCREENING PURSUANT TO GUIDELINE II-T, TO BE SUBMITTED TO THE COURT WITH THE APPLICATION FOR INVOLUNTARY CIVIL COMMITMENT NO LATER THAN THREE DAYS AFTER RECEIPT OF THE APPLICATION.

(2) THE FORM AND CONTENT OF THE SCREENING REPORT SHALL BE CONSISTENT WITH THE OVERVIEW AND REGULATION OF THE COMMITMENT PROCESS BY THE COURTS PRESCRIBED IN GUIDELINES II-A THROUGH II-D.

Prehearing Mental Health Examination and Treatment

GUIDELINE II-W. PREHEARING MENTAL HEALTH EXAMINATIONS OF RESPONDENTS PERFORMED IN INPATIENT MENTAL HEALTH FACILITIES SHOULD BE FUNCTIONALLY AND EXPEDITIOUSLY LINKED WITH BOTH PRIOR SCREENINGS AND INVESTIGATIONS

IN THE COMMUNITY, AND SUBSEQUENT JUDICIAL REVIEWS BEFORE AND DURING COURT HEARINGS. THE SERIES OF SCREENINGS AND EVALUATIONS PURSUANT TO INVOLUNTARY CIVIL COMMITMENT SHOULD BE SIMPLIFIED AND STREAMLINED TO PROVIDE A SUCCESSION OF EFFECTIVE, EFFICIENT CHECKS ON THE APPROPRIATENESS OF THE COMMITMENT PROCEEDINGS AND TO PROVIDE A CUMULATIVE BASE OF FACTS AND EXPERT OPINIONS. JUDGES, COURT ADMINISTRATORS AND MANAGERS, SHOULD BE INSTRUMENTAL IN EFFECTING THE COOPERATION AND COORDINATION AMONG THE VARIOUS UNITS OF THE MENTAL HEALTH-JUDICIAL SYSTEM TO ACHIEVE THESE ENDS.

GUIDELINE II-X. (1) MENTAL HEALTH EXAMINATIONS SHOULD INCLUDE, AT A MINIMUM: (a) A FULL STANDARD MENTAL STATUS EXAMINATION; (b) AN ASSESSMENT OF WHETHER THE RESPONDENT MEETS THE STATUTORY CRITERIA FOR COMPULSORY HOSPITALIZATION; AND, (c) APPROPRIATE DIAGNOSES, PROGNOSES, AND DETERMINATIONS OF COURSES OF TREATMENT AND CARE IN THE LEAST RESTRICTIVE SETTINGS.

(2) MENTAL HEALTH EXAMINATION REPORTS PROVIDED TO THE COURTS SHOULD STATE THE RESULTS OF THE EXAMINATION AS DESCRIBED IN PARAGRAPH (1), THE EXAMINER'S OPINION WHETHER THE RESPONDENT MEETS THE STATUTORY CRITERIA FOR COMMITMENT, AS WELL AS STATEMENTS ALLOWING COURT PERSONNEL TO ASCERTAIN THE FACTUAL BASES OF THE OPINION.

(3) EXAMINERS WHO PREPARE WRITTEN REPORTS SHOULD BE REQUIRED TO INCLUDE IN THOSE REPORTS STATEMENTS INDICATING WHAT PAST PSYCHIATRIC RECORDS AND OTHER EXAMINERS' OPINIONS THEY CONSULTED BEFORE EXAMINING THE RESPONDENT OR PREPARING THEIR WRITTEN REPORTS. EXAMINERS SHOULD BE ENCOURAGED TO INDICATE, WHENEVER POSSIBLE, WHICH OF THEIR CONCLUSIONS DEPEND SUBSTANTIALLY ON THEIR OWN OBSERVATIONS AND WHICH PRIMARILY ECHO OR REINFORCE PRIOR CONCLUSIONS.

(4) A STANDARD PREPRINTED FORM FOR REPORTING RESULTS OF EXAMINATIONS SHOULD BE DEVELOPED AND USED TO EXPEDITE COMMUNCATION.

GUIDELINE II-Y. (1) THE COURT SHOULD MAKE GREATER USE, AND ENCOURAGE ATTORNEYS TO MAKE GREATER USE, OF THE EXAMINATIONS PERFORMED PURSUANT TO INVOLUNTARY CIVIL COMMITMENT.

(2) EXAMINERS SHOULD BE REQUIRED TO COMPLETE THEIR EXAMINATIONS AND TO SUBMIT WRITTEN REPORTS SUFFICIENTLY IN ADVANCE OF JUDICIAL REVIEWS TO ALLOW ADEQUATE TIME FOR CONSIDERATION OF THE EXAMINATION RESULTS.

(3) ONCE THE VALIDITY AND RELIABILITY OF COMMITMENT DECISIONS ARE ESTABLISHED, IN THE INTEREST OF THE RESPONDENT'S CARE AND TREATMENT, THE COURT SHOULD COORDINATE AND COMPILE THE RESULTS OF THE PREHEARING EXAMINATIONS, AND MAKE THESE RESULTS AVAILABLE TO THE MENTAL HEALTH PERSONNEL RESPONSIBLE FOR THE RESPONDENT'S CARE AND TREATMENT.

GUIDELINE II-Z. THE COURTS SHOULD URGE EXAMINERS TO CAREFULLY EXPLAIN TO EVERY RESPONDENT THE RIGHTS OF THE RESPONDENT, AND THE PURPOSE, NATURE, AND LIKELY CONSEQUENCES OF EACH EXAMINATION, INCLUDING ITS PLACE IN THE COMMITMENT PROCEEDINGS.

GUIDELINE II-AA. PREHEARING MENTAL HEALTH TREATMENT AND CARE SHOULD BE ADMINISTERED IN A MANNER CONSISTENT WITH THE APPLICABLE STATE STATUTE, THE PURPOSES FOR WHICH THE RESPONDENT WAS HOSPITALIZED, AND THE ACCEPTED MENTAL HEALTH PRACTICES.

GUIDELINES II-BB. (1) THE POLICIES OF FACILITIES PROVIDING PREHEARING MENTAL HEALTH TREATMENT SHOULD BE INFORMED BOTH BY LEGAL OPINION REGARDING THE LIABILITY OF TREATMENT PROVIDERS, AND BY MENTAL HEALTH OPINION ABOUT THE APPROPRIATENESS OF SHORT-TERM TREATMENT.

(2) THE COURTS, AND ATTORNEYS REPRESENTING RESPONDENTS, SHOULD BE FAMILIAR WITH THE TYPES OF PREHEARING TREATMENT GIVEN TO RESPONDENTS, ESPECIALLY WHEN THE TREATMENT INCLUDES MEDICATION LIKELY TO AFFECT THE RESPONDENT'S DEMEANOR AND CAPACITY TO ASSIST COUNSEL DURING JUDICIAL HEARING.

Diversion and Release Before Judicial Hearing

GUIDELINE II-CC. (1) THE COURTS SHOULD REVIEW, MONITOR, INFLUENCE, AND REGULATE, AS MAY BE APPROPRIATE, THE POLICIES AND PROCEDURES FOR THE RELEASE AND DIVERSION OF RESPONDENTS FROM INVOLUNTARY HOSPITALIZATION PRIOR TO JUDICIAL HEARING.

(2) THE COURTS SHOULD BE AWARE OF: (a) THE TOTAL NUMBER OF RESPONDENTS PASSING THROUGH COMMUNITY PORTALS, TAKEN INTO CUSTODY, AND DETAINED PURSUANT TO INVOLUNTARY HOSPITAL ADMISSION; (b) THE PROPORTION OF THOSE RESPONDENTS WHO ARE REFUSED ADMISSION OR ARE DISCHARGED SHORTLY AFTER ADMISSION; (c) THE PROPORTION CONVERTED TO VOLUNTARY ADMISSION IN THE SAME FACILITY; (d) THE PROPORTION TRANSFERRED TO ANOTHER FACILITY AFTER ADMISSION; AND, (e) THE PROPORTION RELEASED PRIOR TO JUDICIAL HEARING.

(3) TO EXPEDITIOUSLY IMPLEMENT PARAGRAPHS (1) AND (2), MENTAL HEALTH FACILITIES AUTHORIZED TO ADMIT INVOLUNTARY PATIENTS SHOULD BE ENCOURAGED TO COMMUNICATE TO THE COURTS, AND THE COURTS SHOULD BECOME FAMILIAR WITH, THE POLICIES AND PROCEDURES FOR RELEASE AND DIVERSION OF RESPONDENTS.

GUIDELINE II-DD. THE COURTS SHOULD ENCOURAGE ATTORNEYS FOR RESPONDENTS TO DETERMINE WHETHER THEIR CLIENTS WHO HAVE REQUESTED CONVERSION TO VOLUNTARY ADMISSION STATUS, HAVE DONE SO KNOWINGLY AND WILLINGLY.

GUIDELINE II-EE. (1) ONCE A RESPONDENT'S PREHEARING RELEASE OR DIVERSION HAS BEEN JUSTIFIED IN ACCORD WITH LEGAL PROVISIONS, AND ON THE BASIS OF DETERMINATIONS MADE BY MENTAL HEALTH PERSONNEL THAT THE RESPONDENT NO LONGER REQUIRES COMPULSORY HOSPITALIZATION, THE MENTAL HEALTH FACILITY HOLDING THE RESPONDENT SHOULD EXPEDITIOUSLY EFFECT THE RESPONDENT'S RELEASE OR DIVERSION.

(2) COURTS SHOULD ENSURE THAT PARAGRAPH (1) IS IMPLEMENTED.

GUIDELINE II-FF. COURTS SHOULD REQUIRE THAT MENTAL HEALTH AGENCIES PROVIDE NOTICE OF THE RELEASE OR DIVERSION OF A RESPONDENT TO INDIVIDUALS WHO MAY BE INCONVENIENCED BY ATTENDING A SCHEDULED JUDICIAL HEARING OF THE CASE (E.G., WITNESSES, ATTORNEYS), AND TO AGENCIES WITH A LEGITIMATE INTEREST IN THE CONTINUING CARE AND TREATMENT OF THE RESPONDENT.

PART III. RESPONDENT'S COUNSEL

Appointment of Counsel

GUIDELINE III-A. (1) WITHIN THE CONSTRAINTS OF APPLICABLE STATUTE, COUNSEL SHOULD BE APPOINTED FOR ALL INDIGENT RESPONDENTS, AND FOR ALL RESPONDENTS WHO EITHER FAIL OR REFUSE TO RETAIN COUNSEL, REGARDLESS OF FINANCIAL ABILITY.

(2) UNLESS A RESPONDENT IS INDIGENT, OR UNLESS THE COMMITMENT PETITION IS DISMISSED OR DENIED, THE RESPONDENT SHOULD BE REQUIRED TO REIMBURSE THE REASONABLE COST OF APPOINTED COUNSEL. A REGULAR METHOD SHOULD BE ESTABLISHED TO DETERMINE WHETHER A RESPONDENT IS INDIGENT.

(3) IF A RESPONDENT WISHES TO WAIVE THE RIGHT TO COUNSEL AND PROCEED PRO SE, THE COURT SHOULD DETERMINE WHETHER THE PURPORTED WAIVER IS MADE KNOWINGLY,

INTELLIGENTLY, AND VOLUNTARILY. AFTER A VALID WAIVER, THE COURT MAY REQUIRE THAT COUNSEL STAND BY TO ASSIST THE RESPONDENT IF REQUESTED OR IF NECESSARY.

GUIDELINE III-B. UPON ACCEPTANCE OF A VALID PETITION AND OF A TEMPORARY-DETENTION ORDER, THE JUDICIAL OFFICER RESPONSIBLE FOR HANDLING THE INITIATION OF COMMITMENT PROCEEDINGS SHOULD APPOINT COUNSEL FOR A RESPONDENT.

GUIDELINE III-C. (1) IN JURISDICTIONS WITHOUT A PUBLIC DEFENDER OR SIMILAR ADVOCACY SYSTEM, A JUDICIAL OFFICER SHOULD BE RESPONSIBLE FOR ESTABLISHING AND MAINTAINING A LIST OF PRIVATE ATTORNEYS WHO ARE POTENTIAL APPOINTEES. THE OFFICER MIGHT BE THE PERSON WHO ACTUALLY APPOINTS COUNSEL UNDER GUIDELINE III-B.

(2) THE COURT SHOULD ESTABLISH FAIR CRITERIA FOR INCLUDING ATTORNEYS IN THIS LIST, AND FOR REMOVING ATTORNEYS FROM THE LIST.

(3) THE COURT SHOULD REQUIRE ATTORNEYS TO PARTICIPATE IN AN ORIENTATION PROGRAM AS A PREREQUISITE TO INITIAL INCLUSION IN THE LIST, AND A CONTINUING EDUCATION PROGRAM AS A PREREQUISITE TO CONTINUED INCLUSION IN THIS LIST.

(4) JURISDICTIONS USING PRIVATE COURT-APPOINTED COUNSEL SHOULD STUDY AND CONSIDER USING ALTERNATIVE SYSTEMS FOR PROVIDING COUNSEL IN INVOLUNTARY CIVIL COMMITMENT CASES.

Role of Counsel

GUIDELINE III-D. IN HELPING TO SHAPE THE PROPER ROLE OF COUNSEL, A COURT SHOULD ENCOURAGE ATTORNEYS TO CONSIDER THE REALITIES OF THE MENTAL HEALTH-JUDICIAL SYSTEM, INCLUDING STRAINED RESOURCES AND THE NEED FOR COOPERATIVE STRATEGIES.

Functions of Counsel

GUIDELINE III-E. (1) A HEARING JUDGE SHOULD INQUIRE WHETHER THE RESPONDENT'S ATTORNEY HAS ADEQUATELY PREPARED THE CASE. IF LIMITED AVAILABILITY OF INFORMATION OR INSUFFICIENT TIME PREVENTS ADEQUATE PREPARATION, THE COURT SHOULD ENCOURAGE COOPERATION BETWEEN COUNSEL AND INFORMATION SOURCES, SUCH AS TREATMENT PERSONNEL.

(2) COUNSEL SHOULD HAVE TIMELY ACCESS TO ALL TREATMENT AND DIAGNOSTIC RECORDS RELATING TO THE RESPONDENT. IF SUCH ACCESS IS PROVIDED FOR BY

STATUTE, A SIMPLE PROCEDURE SHOULD BE DEVELOPED AND PROMULGATED DESCRIBING A METHOD FOR OBTAINING SUCH RECORDS.

(3) COUNSEL SHOULD HAVE TIMELY ACCESS TO ALL COURT RECORDS RELATING TO THE RESPONDENT. A PROCEDURE FOR ACCOMPLISHING THIS ACCESS SHOULD BE DEVELOPED AND PROMULGATED.

(4) THE COURT SHOULD MAKE KNOWN TO ALL THE PARTICIPANTS IN THE COMMITMENT PROCESS, THAT IT ENCOURAGES COOPERATION WITH THE RESPONDENT'S COUNSEL IN PREPARATION OF THE CASE.

GUIDELINE III-F. RESPONDENT'S ATTORNEY SHOULD NOT BE PERMITTED TO WAIVE A RESPONDENT'S RIGHT TO ATTEND THE HEARING EXCEPT IN EXTRAORDINARY CIRCUMSTANCES. THE COURT SHOULD MAKE SPECIFIC FINDINGS OF FACT CONCERNING THE REASONABILITY OF A REQUEST FOR RESPONDENT'S ABSENCE.

GUIDELINE III-G. A RESPONDENT'S ATTORNEY SHOULD ADVISE THE COURT OF WHETHER THE RESPONDENT IS UNDER THE INFLUENCE OF PSYCHOTROPIC MEDICATION AND OF ANY RESULTING EFFECT ON THE RESPONDENT'S DEMEANOR, APPEARANCE, OR ABILITY TO EFFECTIVELY PARTICIPATE AND ASSIST COUNSEL.

GUIDELINE III-H. RESPONDENT'S COUNSEL SHOULD ADHERE TO THE RULES OF EVIDENCE APPLICABLE IN CIVIL PROCEEDINGS, UNLESS OTHERWISE SPECIFIED. IF CONCLUSORY OR BASELESS OPINIONS ARE UNCHALLENGED BY COUNSEL, THE JUDGE SHOULD EXERCISE DISCRETION TO PURSUE A FULLER EXPLICATION OF DIAGNOSES OR OTHER OPINIONS.

GUIDELINE III-I. (1) IF NOT STATUTORILY REQUIRED, THE MAKING OF A RECORD SHOULD BE AVAILABLE ON REQUEST OF RESPONDENT OR RESPONDENT'S COUNSEL.

(2) ORIENTATION AND CONTINUING EDUCATION OF RESPONDENT'S COUNSEL, AS PROVIDED IN GUIDELINE III-C, PARAGRAPH (3), SHOULD INCLUDE DISCUSSION OF ISSUES CONCERNING THE HEARING RECORD, GIVING SPECIAL ATTENTION TO COUNSEL'S NEED TO SEEK AND ASSURE THE USE OF PROTECTIVE SAFEGUARDS SUCH AS SEALING AND EXPUNGEMENT.

GUIDELINE III-J. (1) THE COURT SHOULD DEVELOP AND PROMULGATE SPECIFIC GUIDELINES CONCERNING THE POSTHEARING RESPONSIBILITIES OF RESPONDENT'S COUNSEL, AS WELL AS PROCEDURES TO IMPLEMENT THESE GUIDELINES.

(2) EVEN IF THE CASE IS TAKEN BY AN ADVOCACY AGENCY, COUNSEL SHOULD BE RESPONSIBLE FOR INFORMING THE CLIENT OF ANY RIGHT TO AN APPEAL SO THAT ANY STATUTORY FILING LIMITS CAN BE MET; SIMILARLY, COUNSEL SHOULD BE RESPONSIBLE FOR SHARING WITH THE ADVOCATE THE FRUITS OF COUNSEL'S CASE PREPARATION.

PART IV. HEARING CHARACTERISTICS

Holding Hearings

GUIDELINE IV-A. (1) A HEARING SHOULD BE HELD NO MORE THAN FIVE (5) DAYS AFTER A PERSON HAS BEEN TAKEN INTO CUSTODY OR A PETITION FOR INVOLUNTARY CIVIL COMMITMENT HAS BEEN FILED, WHICHEVER OCCURS FIRST. A REQUEST FOR A HEARING BY THE RESPONDENT SHOULD NOT BE REQUIRED.

(2) ORDINARILY, CONTINUANCES FOR REASONABLE PERIODS, IF REQUESTED BY THE RESPONDENT, SHOULD BE GRANTED. EXCEPT IN EXTRAORDINARY CIRCUMSTANCES, CONTINUANCES REQUESTED BY OTHER PARTIES SHOULD NOT BE GRANTED OVER THE RESPONDENT'S OBJECTION.

GUIDELINE IV-B. (1) PROCEDURES SHOULD BE ESTABLISHED SO THAT THE DATE, TIME, AND PLACE OF A HEARING MAY BE SET NO MORE THAN ONE DAY AFTER THE PETITION IS FILED.

(2) THE COURT SHOULD ISSUE NOTICE OF THE HEARING IMMEDIATELY AFTER THE HEARING HAS BEEN SCHEDULED. BY THE MOST EXPEDITIOUS MEANS AVAILABLE, THE NOTICE SHOULD BE SENT TO THE RESPONDENT, A CLOSE RELATIVE OR GUARDIAN OF THE RESPONDENT, TO THE RESPONDENT'S ATTORNEY, THE PETITIONER AND HIS OR HER ATTORNEY IF ANY, THE ATTORNEY REPRESENTING THE STATE, THE DIRECTOR OF THE FACILITY IN WHICH THE RESPONDENT IS HOUSED, AND TO ANY OTHER INDIVIDUAL WITH A DIRECT INTEREST IN THE PROCEEDING.

(3) IN ADDITION TO THE DATE, TIME AND PLACE OF THE HEARING, THE NOTICE SENT TO THE RESPONDENT AND TO THE PETITIONER SHOULD CONTAIN AN EXPLANATION OF THE PURPOSE AND POSSIBLE CONSEQUENCES OF THE HEARING. THE RESPONDENT'S COPY SHOULD ALSO CONTAIN AN EXPLANATION OF HIS OR HER RIGHTS AT THE HEARING. ALL EXPLANATIONS SHOULD BE PHRASED IN NON-TECHNICAL TERMS.

(4) THE COURT SHOULD IMPOSE A DUTY ON RESPONDENT'S COUNSEL TO PROVIDE TO THE RESPONDENT AN ORAL EXPLANATION OF THE MATTERS CONTAINED IN THE NOTICE.

GUIDELINE IV-C. (1) UNLESS THE RESPONDENT OBJECTS, HEARINGS MAY BE HELD IN A TREATMENT FACILITY.

(2) HEARINGS NOT HELD IN A REGULAR COURTROOM SHOULD BE CONDUCTED IN A ROOM OF ADEQUATE SIZE, WITH SUFFICIENT DIGNITY AND FORMALITY TO ELICIT THE CUSTOMARY RESPECT AFFORDED COURT PROCEEDINGS.

GUIDELINE IV-D. (1) IF A JUDGE DOES NOT PRESIDE OVER COMMITMENT HEARINGS, THE PRESIDING OFFICER SHOULD BE AN ATTORNEY, APPOINTED BY THE COURT, VESTED WITH THE LEGAL AUTHORITY TO ISSUE NECESSARY ORDERS, AND ABLE TO DECIDE IMPARTIALLY THE MATTERS PRESENTED.

(2) JUDGES AND ATTORNEYS PRESIDING OVER COMMITMENT HEARINGS SHOULD BE CONVERSANT WITH THE STATE MENTAL HEALTH LAWS AND PROCEDURES, THE CONSTITUTIONAL PRINCIPLES APPLICABLE TO MENTAL HEALTH PROCEEDINGS, AND THE AVAILABLE TREATMENT PROGRAMS. COMMITMENT HEARINGS SHOULD BE A REGULAR PART OF THEIR DUTIES BUT NOT THEIR ONLY JUDICIAL DUTY.

Opportunity for Voluntary Admission

GUIDELINE IV-E. (1) AT OR BEFORE THE HEARING ON A PETITION FOR INVOLUNTARY CIVIL COMMITMENT, COUNSEL FOR THE RESPONDENT SHOULD BE REQUIRED TO CERTIFY THAT HE OR SHE HAS ADVISED THE RESPONDENT OF THE RIGHT TO REQUEST VOLUNTARY ADMISSION, AND HAS EXPLAINED THE PROCEDURES FOR REQUESTING ADMISSION AND THE LEGAL CONSEQUENCES OF BEING ADMITTED VOLUNTARILY RATHER THAN BY COURT ORDER. THE ATTORNEY SHOULD CERTIFY FURTHER THAT THE RESPONDENT HAS RECEIVED EXPLANATION OF THE TYPE(S) OF TREATMENT THAT WOULD BE OFFERED FOLLOWING A VOLUNTARY ADMISSION.

(2) IF NO CERTIFICATION HAS BEEN FILED, THE COURT SHOULD BRIEFLY ADJOURN THE PROCEEDINGS AND DIRECT RESPONDENT'S ATTORNEY TO PROVIDE THE SPECIFIED INFORMATION AND EXPLANATIONS.

GUIDELINE IV-F. (1) IF A REQUEST FOR VOLUNTARY ADMISSION HAS BEEN MADE BY A RESPONDENT IN A COMMITMENT PROCEEDING, THE COURT SHOULD NOT DISMISS THE PETITION UNLESS COUNSEL FOR THE RESPONDENT HAS CERTIFIED IN WRITING THAT HE OR SHE HAS DISCUSSED THE REQUEST WITH THE RESPONDENT, AND REASONABLY BELIEVES THAT THE REQUEST IS NOT THE RESULT OF THREAT OR COERCION AND THAT THE REQUEST WAS MADE WITH KNOWLEDGE OF THE LEGAL AND TREATMENT CONSEQUENCES.

(2) IF COUNSEL IS UNABLE TO SO CERTIFY, THE COURT SHOULD CONDUCT AN INQUIRY INTO THE CIRCUMSTANCES SURROUNDING THE RESPONDENT'S REQUEST. THIS INQUIRY SHOULD OCCUR, WHENEVER POSSIBLE, AT THE DATE AND TIME SET FOR THE COMMITMENT HEARING. IF THE COURT

DETERMINES THAT THE REQUEST WAS KNOWING AND VOLUNTARY, OR IF THE RESPONDENT RENEWS THE REQUEST AFTER A DISCUSSION OF HIS OR HER RIGHTS AND THE COUNSEQUENCES OF VOLUNTARY ADMISSION, THEN THE INVOLUNTARY COMMITMENT PETITION SHOULD BE DISMISSED. IF THE REQUEST IS NOT FOUND TO HAVE BEEN MADE KNOWINGLY AND VOLUNTARILY, AND THE RESPONDENT DOES NOT EXECUTE A KNOWING AND VOLUNTARY REQUEST FOR ADMISSION FOLLOWING THE INQUIRY, THE COURT SHOULD PROCEED WITH THE INVOLUNTARY COMMITMENT PROCEEDING.

GUIDELINE IV-G. FOLLOWING DENIAL OF A REQUEST FOR VOLUNTARY ADMISSION MADE BY A PERSON AGAINST WHOM AN INVOLUNTARY CIVIL COMMITMENT PETITION IS PENDING, THE OFFICIAL DENYING THE REQUEST SHOULD BE REQUIRED TO FILE A STATEMENT WITH THE COURT. THIS STATEMENT SHOULD SET FORTH THE FACTS AND REASONS UPON WHICH THE DENIAL IS BASED. ON MOTION OF THE RESPONDENT, THE COURT SHOULD CONDUCT AN INQUIRY INTO THE DENIAL OF THE REQUEST. IF IT IS DETERMINED THAT THE FACILITY IN UNABLE TO PROVIDE APPROPRIATE TREATMENT TO THE RESPONDENT OR THAT THE REQUEST WAS FILED IN ORDER TO AVOID TREATMENT, THE COURT SHOULD PROCEED WITH THE INVOLUNTARY COMMITMENT HEARING. IF IT IS FOUND THAT THE DENIAL WAS IMPROPER, AND THE RESPONDENT KNOWINGLY AND VOLUNTARILY RENEWS THE REQUEST, THE COULD SHOULD DIRECT THAT THE RESPONDENT BE VOLUNTARILY ADMITTED.

Criteria for Involuntary Commitment

GUIDELINE IV-H. (1) A RESPONDENT SHOULD BE FOUND NOT ELIGIBLE FOR INVOLUNTARY CIVIL COMMITMENT UNLESS THE PETITIONER, OR THE STATE ON THE PETITIONER'S BEHALF, HAS PRESENTED CLEAR AND CONVINCING PROOF OF EACH OF THE CRITERIA FOR COMMITMENT PRESCRIBED BY LAW. THE PETITIONER, OR THE STATE, SHOULD DISTINGUISH BETWEEN THOSE ELEMENTS RELATING TO ELIGIBILITY FOR COMMITMENT, AND THOSE RELATING TO THE TYPE OF AND APPROPRIATE SETTING FOR TREATMENT.

(2) FOR A PETITIONER TO DEMONSTRATE THAT, AS A RESULT OF MENTALL ILLNESS, A RESPONDENT IS DANGEROUS, A COURT SHOULD REQUIRE PROOF THAT (a) THE RESPONDENT HAS RECENTLY THREATENED, HAS ATTEMPTED TO INFLICT, OR HAS ACTUALLY INFLICTED SUBSTANTIAL PHYSICAL HARM UPON HIM OR HERSELF OR UPON ANOTHER PERSON, AND THAT (b) THE RESPONDENT IS STILL SO MENTALLY ILL THAT THERE IS A SUBSTANTIAL LIKELIHOOD THAT HE OR SHE WILL INFLICT OR ATTEMPT TO INFLICT SUCH HARM IF RELEASED WITHOUT FURTHER TREATMENT.

(3) FOR A PETITIONER TO DEMONSTRATE THAT, AS A RESULT OF MENTAL ILLNESS, A RESPONDENT IS UNABLE TO PROVIDE

FOR HIS OR HER BASIC PHYSICAL NEEDS, A COURT SHOULD REQUIRE PROOF OF (a) OBSERVABLE BEHAVIORS WHICH HAVE RESULTED IN (b) LACK OF SHELTER, FOOD, CLOTHING, OR BASIC HYGIENE, RESULTING IN OR LIKELY TO RESULT IN (c) SERIOUS PHYSICIAL HARM TO THE PERSON. FURTHER, THE PETITIONER MUST DEMONSTRATE A SUBSTANTIAL LIKELIHOOD THAT, WITHOUT TREATMENT, THESE BEHAVIORS WILL CONTINUE.

Procedural Issues

GUIDELINE IV-I. (1) A RESPONDENT SHOULD BE ENTITLED TO ATTEND ANY HEARING REGARDING THE PETITION FOR INVOLUNTARY CIVIL COMMITMENT. A COURT SHOULD NOT ACCEPT A RESPONDENT'S WAIVER OF THE RIGHT TO BE PRESENT, UNLESS COUNSEL FOR THE RESPONDENT CERTIFIES IN WRITING THAT HE OR SHE HAS DISCUSSED THIS RIGHT WITH THE RESPONDENT, AND REASONABLY BELIEVES THAT THE WAIVER WAS MADE KNOWINGLY AND VOLUNTARILY. A JUDGE SHOULD ONLY REMOVE A RESPONDENT FROM A HEARING IF, AFTER THE JUDGE'S WARNING THAT HE WILL BE REMOVED IF HIS DISRUPTIVE BEHAVIOR CONTINUES, HE OR SHE NEVERTHELESS CONTINUES TO BE SO DISRUPTIVE THAT THE TRIAL CANNOT PROCEED IN AN ORDERLY MANNER.

(2) DURING THE HEARING, RESPONDENTS SHOULD NOT BE UNDER THE INFLUENCE OF PSYCHOTROPIC MEDICATION UNLESS ADMINISTRATION OF THE DRUG IS ESSENTIAL TO PROTECT THE RESPONDENT OR OTHERS FROM SERIOUS BODILY HARM AND UNLESS NO LESS SEVERE MEANS WOULD PROVIDE SUCH PROTECTION.

(3) IF ADMINISTRATION OF PSYCHOTROPIC MEDICATION IS UNAVOIDABLE, THE JUDGE SHOULD INQUIRE CONCERNING THE EFFECTS OF THE DRUG, SO THAT THE ALTERATION OF THE RESPONDENT'S APPEARANCE, DEMEANOR, OR ACTIONS, DOES NOT IMPROPERLY INFLUENCE THE DECISION-MAKING PROCESS.

GUIDELINE IV-J. (1) EACH PARTY SHOULD BE ENTITLED TO SUBPOENA WITNESSES AND EVIDENCE, AND TO CROSS-EXAMINE ADVERSE WITNESSES.

(2) A COURT SHOULD REQUIRE TESTIMONY FROM AT LEAST ONE PERSON WHO OBSERVED THE RESPONDENT'S CONDUCT PRIOR TO THE FILING OF THE INVOLUNTARY COMMITMENT PETITION, AND FROM AT LEAST ONE PSYCHIATRIST OR CLINICAL PSYCHOLOGIST WHO PERSONALLY EXAMINED THE RESPONDENT AFTER THE FILING OF THE PETITION.

GUIDELINE IV-K. (1) INVOLUNTARY COMMITMENT HEARINGS SHOULD BE GOVERNED BY THE RULES OF PROCEDURE AND EVIDENCE APPLICABLE IN CIVIL PROCEEDINGS, UNLESS OTHERWISE SPECIFIED.

(2) THAT A RESPONDENT HAS PREVIOUSLY BEEN INVOLUNTARILY COMMITTED OR THAT THE CONDUCT ALLEGED IN THE PETITION ALSO FORMS THE BASIS OF CRIMINAL CHARGES AGAINST THE RESPONDENT, SHOULD NOT CONSTITUTE EVIDENCE THAT THE RESPONDENT CURRENTLY MEETS THE CRITERIA FOR INVOLUNTARY CIVIL COMMITMENT.

GUIDELINE IV-L. A COURT SHOULD NOT ACCEPT A RESPONDENT'S WAIVER OF THE RIGHT TO A JURY, UNLESS COUNSEL FOR THE RESPONDENT HAS CERTIFIED IN WRITING THAT HE OR SHE HAS DISCUSSED THIS RIGHT WITH THE RESPONDENT, AND REASONABLY BELIEVES THAT THE WAIVER WAS MADE KNOWINGLY AND IS NOT THE RESULT OF THREAT OR COERCION.

GUIDELINE IV-M. (1) IN THE ABSENCE OF A STATUTORY PROVISION TO THE CONTRARY, INVOLUNTARY CIVIL COMMITMENT HEARINGS SHOULD BE OPEN TO THE PUBLIC, UNLESS A RESPONDENT'S REQUEST FOR A CLOSED HEARING IS APPROVED. THE COURT SHOULD GRANT SUCH A REQUEST EXCEPT WHEN THE RESPONDENT HAS PLACED HIS OR HER MENTAL HEALTH AT ISSUE IN A RELATED PUBLIC PROCEEDING.

(2) AT THE BEGINNING OF THE HEARING, THE COURT SHOULD INQUIRE WHETHER THE RIGHT TO REQUEST CLOSED PROCEEDINGS HAS BEEN EXPLAINED TO THE RESPONDENT. IF NOT, THE COURT SHOULD DIRECT COUNSEL TO EXPLAIN THIS RIGHT TO THE RESPONDENT. AFTER THE EXPLANATION, IF A REQUEST TO CLOSE THE HEARING IS APPROVED, THE ONLY PERSONS PRESENT SHOULD BE THE JUDGE, NECESSARY COURT PERSONNEL, THE PARTIES, EACH PARTY'S COUNSEL AND FAMILY, AND OTHER PERSONS SPECIFICALLY APPROVED BY THE COURT. THE COURT SHOULD INSTRUCT PERSONS PRESENT TO NOT DIVULGE INFORMATION CONCERNING THE PROCEEDINGS TO EXCLUDED PERSONS.

GUIDELINE IV-N. A VERBATIM RECORD SHOULD BE MADE OF ALL INVOLUNTARY COMMITMENT HEARINGS.

GUIDELINE IV-O. (1) UPON THE DENIAL OR DISMISSAL OF A PETITION FOR COMMITMENT, ALL COURT RECORDS REGARDING THE COMMITMENT PROCEEDINGS, THAT MIGHT REVEAL THE RESPONDENT'S IDENTITY, SHOULD BE DESTROYED, PROVIDED THAT THE RESPONDENT FILES A FULL RELEASE OF ALL POTENTIAL CLAIMS AGAINST ANY PERSON OR AGENCY ARISING OUT OF THE PROCEEDINGS. IF THE RESPONDENT DECLINES TO PROVIDE SUCH A RELEASE, THE RECORDS SHOULD BE SEALED. SEALED RECORDS SHOULD BE DISCLOSED ONLY TO THE EXTENT NECESSARY FOR THE DEFENSE OF CLAIMS FILED BY OR ON BEHALF OF THE RESPONDENT.

(2) BEFORE THE RECORDS ARE DESTROYED, A RESPONDENT SHOULD BE PROVIDED WITH A COPY OF THE ORDER DENYING OR

DISMISSING THE PETITION, AND SHOULD BE GIVEN AN OPPORTUNITY TO OBTAIN ANY OTHER PORTION OF THE COURT RECORD.

PART V. TREATMENT CONSIDERATIONS DURING JUDICIAL HEARING

Treatment Plan

GUIDELINE V-A. (1) THE HOSPITAL DIRECTOR, OR HIS OR HER DESIGNEE, SHOULD SUBMIT A PRELIMINARY TREATMENT PLAN TO THE COURT, TOGETHER WITH THE MENTAL HEALTH EXAMINER'S REPORT. THE COURT SHOULD PROVIDE A COPY TO ALL PARTIES.

(2) THE PRELIMINARY PLAN SHOULD BE PREPARED BY THE EXAMINING PSYCHIATRIST(S), CLINICAL PSYCHOLOGIST(S), OR OTHER MEMBERS OF THE TREATMENT TEAM, AND SHOULD SPECIFY (a) THE PROPOSED TREATMENT GOALS, (b) THE SERVICES AND TREATMENT METHODS AVAILABLE TO ASSIST IN MEETING THOSE GOALS, (c) WHICH OF THESE SERVICES AND TREATMENT METHODS ARE MOST LIKELY TO ASSIST THE RESPONDENT, (d) THE PROPOSED TREATMENT SETTING AND REASONABLE ALTERNATIVES THERETO, AND (e) AN ESTIMATE OF THE TIME REQUIRED TO ACHIEVE THE TREATMENT GOALS. THIS PLAN SHOULD BE TAILORED TO THE RESPONDENT'S NEEDS. EXCEPT IN THE DESCRIPTION OF AVAILABLE SERVICES, STANDARDIZED PROVISIONS SHOULD NOT BE USED.

(3) TO THE MAXIMUM EXTENT POSSIBLE, THE RESPONDENT SHOULD BE INVOLVED IN THE PREPARATION OF HIS OR HER PRELIMINARY TREATMENT PLAN.

GUIDELINE V-B. (1) NO MORE THAN 30 DAYS AFTER THE RESPONDENT HAS BEEN FOUND TO MEET THE CRITERIA FOR INVOLUNTARY CIVIL COMMITMENT, OR WITHIN SUCH SHORTER PERIOD AS THE COURT MAY PRESCRIBE, THE AGENCY OR INDIVIDUAL RESPONSIBLE FOR PROVIDING OR COORDINATING SERVICES AND TREATMENT FOR THE RESPONDENT, SHOULD SUBMIT A FULL TREATMENT PLAN TO THE COURT. THE COURT SHOULD PROVIDE A COPY OF THE PLAN TO ALL PARTIES AND TO RESPONDENT'S COUNSEL.

(2) THE FULL TREATMENT PLAN SHOULD BE TAILORED TO THE RESPONDENT'S NEEDS. STANDARDIZED PROVISIONS SHOULD NOT BE USED. THE PLAN SHOULD INCLUDE (a) A DETAILED EVALUATION OF THE RESPONDENT'S STRENGTHS, PROBLEMS, AND NEEDS, (b) A DESCRIPTION OF THE SERVICES AND TREATMENT ADMINISTERED TO THE RESPONDENT AFTER HE OR SHE WAS TAKEN INTO CUSTODY AND DETAINED PURSUANT TO INVOLUNTARY COMMITMENT, (c) A DESCRIPTION OF THE SERVICES AND TREATMENT PROPOSED, AND OF HOW THESE WILL ASSIST THE RESPONDENT IN MEETING TREATMENT OBJECTIVES,

TOGETHER WITH POSSIBLE SIDE EFFECTS, AND AVAILABLE ALTERNATIVES, (d) THE AGENCIES AND INDIVIDUALS WHO WILL PROVIDE THE SERVICES AND TREATMENT, (e) THE SETTING IN WHICH THE SERVICES AND TREATMENT WILL BE PROVIDED, (f) AN EXPLANATION OF HOW PROGRESS TOWARD THE GOALS WILL BE MEASURED AND OF THE PROJECTED TIMETABLE FOR ATTAINING THE GOALS, (g) A STATEMENT OF CRITERIA FOR TRANSITION TO LESS RESTRICTIVE SERVICES, TREATMENT, OR PLACEMENTS, AND FOR DISCHARGE FROM SERVICES AND TREATMENT, AS WELL AS THE PROJECTED DATE FOR TRANSITION OR DISCHARGE, AND (h) THE SIGNATURES OF THE PREPARERS, AND THE DATE.

(3) TO THE MAXIMUM EXTENT POSSIBLE, THE RESPONDENT SHOULD BE INVOLVED IN THE PREPARATION OF HIS OR HER TREATMENT PLAN.

GUIDELINE V-C. (1) THE PARTIES SHOULD BE ENTITLED TO PRESENT EVIDENCE AND ARGUMENT REGARDING THE PRELIMINARY TREATMENT PLAN DURING THE DISPOSITIONAL PHASE OF THE COMMITMENT HEARING. THE COURT SHOULD HAVE THE AUTHORITY TO APPROVE OR MODIFY THE PRELIMINARY TREATMENT PLAN, OR ORDER THAT THE SUBMISSION OF A FULL TREATMENT PLAN BE EXPEDITED.

(2) WITHIN FIVE DAYS AFTER SUBMISSION OF THE FULL TREATMENT PLAN, ANY PARTY SHOULD BE ENTITLED TO REQUEST A PROMPT HEARING TO REVIEW THE PLAN. THE REQUEST SHOULD INDICATE THE PARTS OF THE PLAN TO BE CHALLENGED. AT THE HEARING, THE COURT SHOULD BE ENTITLED TO APPROVE, MODIFY, OR ORDER REVISION OF, THE FULL TREATMENT PLAN.

Dispositional Decision

GUIDELINE V-D. THE COURT SHOULD MINIMIZE PRESENTATION OF EVIDENCE AND ARGUMENT REGARDING THE APPROPRIATE DISPOSITION UNTIL AFTER A FINDING THAT THE RESPONDENT MEETS THE COMMITMENT CRITERIA.

GUIDELINE V-E. THE COURT SHOULD PREPARE AND MAINTAIN A FILE OF ALL MENTAL HEALTH TREATMENT PROGRAMS AND FACILITIES WITHIN ITS JURISDICTION, INCLUDING THE SERVICES OFFERED, THE ELIGIBILITY REQUIREMENTS IMPOSED, AND THE COSTS INVOLVED.

GUIDELINE V-F. AFTER REVIEWING THE TREATMENT PLAN, AND CONSIDERING THE EVIDENCE AND ARGUMENTS PRESENTED, THE COURT SHOULD IMPOSE THE LEAST RESTRICTIVE DISPOSITIONAL ALTERNATIVE THAT WILL ACHIEVE APPROPRIATE TREATMENT GOALS.

PART I

INTRODUCTION

Contents

CHAPTER ONE

OVERVIEW AND PLAN OF THE PROVISIONAL GUIDELINES

The commitment of an individual to a mental institution against his or her will is a process that troubles people of good conscience. It brings into conflict two of society's most strongly held values: the State's interest in the treatment of the mentally ill and the individual's interest in liberty.

The process of involuntary civil commitment is rooted in the legal theory of parens patriae. Until the 1960s, it was the position of most states that because the individual's best interests were the object of the commitment proceeding, it was unnecessary to provide the kinds of due process protections guaranteed in criminal proceedings. In recent years, however, courts and legislatures have shown an increasing sensitivity to the individual's liberty interest. Noting that the consequences of commitment include not only deprivation of freedom, but often unwanted behavior modification ("mind control"), stigma in the community, and loss of many civil rights as well (historically including the rights to vote, drive, marry, and divorce), dozens of states have amended their commitment statutes in the last decade.

In most states today, respondents in commitment proceedings are accorded an array of procedural due process protections. Virtually all states provide the respondent with the right to a hearing to challenge his commitment. Many states allow prehearing detention only on an emergency basis, and most require that a preliminary hearing be held promptly to establish probable cause for continued detention. Prehearing detention in a jail generally is prohibited. The right to counsel is universally recognized, and the appointment of counsel for indigent respondents is authorized in most states. Many states permit the respondent to be examined by a mental health professional of his or her own choosing, and a few have recognized a right to refuse to speak with the examiner.

A jury trial is available in many states to determine longer term commitment and the right to appeal a commitment order is provided in most. The United States Supreme Court has ruled that the burden of proof necessary to commit must meet at lease the "clear and convincing" standard. Some states require proof beyond a reasonable doubt. Most states accord the respondent the right to be present at the commitment hearing; provisions for waiving this right are typically quite restrictive.

Some observers believe that the introduction of due process protections has made it unreasonably difficult to commit and treat persons who really need this help. Reports are appearing of seriously psychotic persons who are not being petitioned against or whose institutionalization is being successfully resisted. It is claimed that although such persons maintain their liberty rights, they suffer severe consequences from not receiving the treatment they need. A few observers suggest that the stricter commitment requirements, employing so many of the protections previously reserved for criminal defendants, have had the ironic effect of diverting many mentally ill persons into the criminal

process. These observers further suggest that the "criminalization" of the commitment process has resulted in a decrease in civil commitments accompanied by a corresponding increase in criminal prosecutions of persons for acts suggesting mental aberration. Although few suggest revoking any of the recently invoked legal protections, many are concerned about the wisdom of further expanding these protections. Other observers have commented that although the laws have changed dramatically in recent years, the practice of commitment has remained relatively unchanged. Indeed, it has been alleged that the new statutes as applied enhance respondents' liberty protections very little.

The distinguishing characteristic of the involuntary civil commitment process may well be the disputatious nature of virtually all issues relating to it. This sharp disagreement about the law and its application is reflected in the provisional guidelines and accompanying commentary in this volume.

A general summary of these perplexing problems concerning civil commitment, prepared by Joel Zimmerman, Larry Fitch and Paul Barnett of the ICCP staff, was developed in the first few months of this project to frame the important issues. This issue paper was subsequently published as "Involuntary Civil Commitment: The Discerning Eye of the Law" (State Court Journal, 5(4), p. 5, (1981)). The interested reader is referred to this issue paper and other commentaries for further discussion of general issues and trends in involuntary civil commitment.

Identification of Problems

The purpose of this volume is to provide specific solutions to specific problems. The exploration of general issues and trends in involuntary civil commitment is not a principal goal of this project. Such an effort is beyond the scope of this volume. The specific problems addressed in the provisional guidelines fall into four general categories. These four categories are identified and outlined briefly below.

(1) Too much emphasis is placed on substantive rather than procedural and practical changes. Despite evidence that major substantive changes in civil commitment laws have had little impact on practice, lawyers and mental health personnel are still focusing on effecting changes in substantive law. Their energies may be more expeditiously spent on the direct improvement of practice, customs, and mores, involved in the implementation of existing laws. Although the provisional guidelines in this volume speak to matters of substantive law, they do so only indirectly, and simply because substance is intertwined with procedure. The emphasis is squarely on procedures and practice.

(2) Procedures are too complex and impractical. In the last twenty years a strong trend in involuntary civil commitment has caused due process, criteria and standards, evidentiary procedures, and adversary process, to approach the rigor of the criminal process. This trend is epitomized in the decision of Lessard v. Schmidt (349 F Supp. 1078 (E. D. Wis. 1972); see also McGarry and Associates, Civil Commitment and Social Policy. Rockville, Maryland: National Institute of Mental Health, 1981). Too often this rigorous adversarial approach has proven unworkable, requiring complex and onerous procedures, and demanding excessive resources and time of the mental health-judicial system. Strict legal requirements frequently are simply ignored or subverted. Enforcement of legal safeguards, when successful, has drained more energies with little benefit to patients, and often has resulted in ritualistic, meaningless, and costly procedures.

A greater emphasis needs to be given to practical considerations, to making the implementation of existing laws workable within the context of the complex interorganizational network comprising the mental health-judicial system. The provisional guidelines seek to do this by proposing more efficient management of the resources available to judges, court administrators, and managers, and by proposing the development and use of simplified and streamlined procedures.

(3) Too little attention is paid to the prehearing aspects of commitment proceedings. Though most commentators consider the judicial hearing to be the centerpiece of the involuntary civil commitment process, the occurences before such hearings can be much more important in individual cases, and can have pervasive effect on the commitment process and the work of the court as a whole. The ease or difficulty with which compulsory hospitalization can be effected, the number and quality of mental health screenings and evaluations, and the opportunities before judicial hearing for diversion from compulsory hospitalization can literally mean the difference between prehearing freedom and compulsory confinement for days or weeks. Courts pay far too little attention to the prehearing aspects of commitment proceedings.

In recognition to the discrepancy between judicial involvement and the importance of prehearing matters, the Provisional Guidelines places great emphasis -- 32 of 71 guidelines -- on the prehearing aspects of the commitment process (see Part II). The increased emphasis on prehearing matters is balanced by a call for judicial restraint in posthearing matters (see Part VI).

(4) Not enough cooperation exists among components of the mental health-judicial system. In the decades of the sixties and seventies, the humane and fair treatment of mentally ill persons became a civil rights issue of the first order. The involuntary civil commitment of allegedly mentally ill persons to large public institutions came under close public scrutiny and attack. As a result, a major reform movement led to the provision of significant rights and legal safeguards for mentally aberrant individuals facing compulsory hospitalization. These gains were largely the result of aggressive advocacy groups and the

mental health system. The major problems which made these confrontational tactics necessary -- patient abuse and an unresponsive mental health delivery system -- now may be largely gone. Instead, the dominant problem now seems to be how to achieve cooperation among the many groups and agencies that work with involuntarily committed patients. Solutions to this problem entail a delineation of responsibilities and division of labors in recognition that rights promotion, and improvement of mental health services, is an immense job that cannot be done by the courts alone. A litigious approach to involuntary civil commitment, successful and necessary in the past, now may have given way to cooperation as the best approach to promoting positive change.

The development of cooperative strategies among courts, law enforcement agencies, community mental health centers, hospitals, and advocacy groups, is urged in many of the guidelines in this volume, especially in Part II, "Prehearing Matters."

Plan of this Volume

The Parts II through VI of this volume are organized roughly according to the typical chronology of events in the involuntary civil commitment process, from the initiaion of commitment proceedings through judicial hearing, to posthearing matters. This chronological order is, of course, inexact. Some events happen in different sequences from jurisdiction to jurisdiction and from case to case. Some considerations, such as the role of counsel (dealt with separately in Part III), are relevant throughout most of the commitment process. Many considerations are artificially divided for the sake of clear exposition. This has been done in considering judicial hearings: Part IV considers the judicial determination of whether an allegedly mentally disturbed person should be committed; Part V considers treatment concerns during judicial hearings. If both issues are raised, they normally are considered at a single hearing. No suggestion is intended that the issues should be raised at separate hearings, or even that the issues are unrelated. Conceptually, however, it seems useful to consider first the question of whether the person should be ordered into treatment. If involuntary treatment is found inappropriate, the remaining issues would be moot. If treatment is deemed appropriate, however, questions regarding treatment alternatives and conditions should then be considered.

Parts II through VI are based, in large part, upon extensive study of specific involuntary civil commitment processes throughout the country. Part VII is a summary of conclusions about and recommendations for improvements of the involuntary civil commitment systems in five metropolitan areas in the United States: Chicago, Columbus (Ohio), Winston-Salem (North Carolina), Los Angeles, and New York City. Each chapter in Part VII is an excerpt from one of five Institute reports previously published.

Parts II through VI of this volume have a consistent format, though they vary considerably in length. Each part begins with a separate table of contents and a general introduction, and each part is divided into chapters. The reader is referred to the table of contents and introduction to these parts for a brief overview of the topics dealt with in each part.

The 71 provisional guidelines are presented throughout Parts II through VI in the context of general discussions of law and of commentary relevant to specific guidelines. Each Part is divided into chapters and each chapter is divided into two sections: "THE LAW" and "GUIDELINES". In many chapters, these sections are divided into subsections. The GUIDELINES section in each chapter contains the provisional guidelines, distinguished from the text by indentation and uppercase type. Provisional guidelines are numbered consecutively within each part and are followed by commentary.

The discussions of law preceding GUIDELINES sections are limited to providing a broad overview of statutory variations in specific areas of law. The overview is necessarily over-simplified and is not intended as a law review. The intent is to communicate the important concepts incorporated in statutes, not to cite specific statutory language. Where differences in language do not seem to reflect important differences in concept, statutes are considered equivalent for purposes of this document. The states listed as examples are neither exclusive nor exhaustive. Other states, which are not listed, also may be valid examples. States may have several statutory provisions relating to any particular consideration in THE LAW sections. Listing a state as an example for one statutory variation should not necessarily indicate that the state does not also incorporate other relevant variations in its statute. Case law has been incorporated into this document, but not in a comprehensive or consistent manner. No attempt has been made to locate all relevant case law.

As suggested above, this report is not a scholarly analysis of general issues in mental health law. It contains few 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 the ICCP. To cite professional literature as it relates to the manifold aspects of this volume would have been an enormous task that would have increased the bulk of this report significantly. The 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. No pretense is made that the philosophical and technical ideas raised in this volume are original, and apologies are made to the numerous authors to whom no direct credit is given.

This volume relates only to the involuntary civil commitment of mentally ill adults. It is not meant to be accurate with reference to prisoners, minors, mentally retarded or developmentally disabled persons, or "sexual offenders" who are alleged to be mentally ill. Some of the

contents of this volume has obvious relevance to these special populations of people. Those populations also are subject to special considerations, however, that seriously qualify this volume's applicability to them.

Some terms used throughout this volume deserve special comment. These comments are noted here so that subsequent usage of the terms will be clear. No further definition will be given as the terms are used. The most important term is "commitment" and its various forms and derivatives. The current vogue is to not use this word because of its strong negative connotations. In its place, some people are using the term "hospitalization." The terms "commitment" and "hospitalization" both are used in this volume for two reasons. First, those are terms that are commonly used in speech, readily recognized, and well understood. Second, in many 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 even this is not accurate in a system such as Ohio's, for example, in which a patient, though committed, still may refuse treatment. Although the term "court-ordered" might be a good substitute for "committed", statutes in some states make it possible for people to be committed without the involvement of a court. Thus, the search for an appropriate synonym is frustrated and the word "commitment" is used despite the stigma associated with it. Perhaps the ultimate solution to this problem will be reform of civil commitment law and mental health practices, and subsequent re-education of the public, so that the stigma, not the word, eventually disappears.

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

CHAPTER TWO

STUDY METHODS

This chapter considers the perspective with which the ICCP, Phase 1, was developed, and methods which were used to acquire the information that is contained in this volume.

Perspective

It is impossible to consider the involuntary civil commitment system without confronting differences of opinion and conflicting attitudes about mental illness and society's proper response and responsibility. A mental health system will be appreciated to the extent that it can accomplish two fundamental objectives. Because of the perceived need for treatment of mentally ill individuals and because of society's responsibility to respond to that need, some people value a system that can easily provide treatment and care, even if treatment and care must be coerced. Others value a mental health system to the extent that it can protect individuals from having hospitalization or treatment thrust upon them against their will. For ease of reference, the first of these perspectives will be referred to as the "helping attitude" and the second as the "liberty attitude."

This volume attempts 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, however, that people who subscribe firmly to the helping attitude propound the elimination of all individual rights. They may maintain a strong orientation toward respecting patients, minimizing unnecessary restrictions, providing humane and adequate care, and so on. At 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 cause for concern; but, they argue, it should be handled through the criminal, rather than the civil, justice system.

Try as one may to balance the helping attitude and the liberty attitude, many situations arise in civil commitment procedures that bring these two attitudes into sharp conflict. Although the objectives of helping people and protecting freedom are not necessarily contradictory, decisions arise where the two attitudes may compel contradictory procedures. 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 impossible to always avoid, and occasionally will force a choice between one or the other.

The perspective taken in this volume is similar to that of courts faced with difficult practical problems. This perspective is not necessarily neutral. The emphasis is squarely on the improvement of everyday practices in involuntary civil commitment systems, practices which often are incongruent with state statutes and mental health law theory, and practices that should, without more, reflect the best intents of existing law.

The aim of the ICCP in conducting studies of involuntary civil commitment procedures throughout the country was 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. Balancing is nothing new to courts. 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 mentally disturbed individuals; (3) the community's interest in protecting itself from dangerous persons; and, (4) the court's interest 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, must make decisions within the context of (1) an ever-shifting array of legal requirements, (2) resource allocations from different sources in the mental health-judicial system, and, (3) an interorganizational network governed by regulations and policies sometimes differing from those of the court.

In the final analysis, the decision between individual 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 may entail judgments that should be made by 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. The aim of the Provisional Guidelines is to help those individuals who must make these difficult decisions everyday. In brief, the perspective 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.

Data Collection

The primary data collection method was field research conducted by ICCP staff in five metropolitan areas throughout the country. Field research was supplemented by the collection of relevant literature and

background documentary materials, and the survey of a limited number of expert opinions.

Literature Review. Beginning in January 1981, ICCP 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 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 ICCP 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 ICCP National Advisory Board were particularly helpful in locating valuable literature.

Just prior to a 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 the "Issues Paper" was altered slightly and published as "Involuntary Civil Commitment: The Discerning Eye of the Law" (State Court Journal, 5(4), p. 5 (1981); available from the National Center for State Courts Publication Department.)). At their meeting, members of the board helped ICCP 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. Using this scheme, 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 ICCP 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 Institute and formed the basis of THE LAW sections in this volume. 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 ICCP states.

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

Preliminary Field Work. A preliminary visit was made to four of the funded project sites. The preliminary visit served several purposes. First, the participants in the civil commitment systems told staff their perceptions of how the systems worked. They noted problems with the systems and peculiarities that set it aside from most others and answered questions about the system.

During the preliminary visit, cooperation was pledged for ICCP research project. Staff of the courts and the mental health agencies invited the ICCP research team to include them in the data collection effort and generously offered their help.

Field Studies. Intensive data-collection trips to each of the five funded sites followed the completion of the comparative statutory analysis. During the two weeks prior to the site visit, intensive preparations were made. Important individuals 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 relevant statutes and case law and identified questions of particular theoretical or practical concern for the specific site. Interview guides were mailed to people who were to be interviewed so that they could review the areas of concern in advance and prepare for the interviews if they wished.

Three major activities were undertaken during site visits: interviews, observations, and staff discussions. Most participants were interviewed individually, although some were interviewed in groups. With very few exceptions, all interviews were conducted by two or three staff members. Before each interview, one staff person was assigned the role of "scribe." While the other person attended carefully to substance and led the interview, the scribe's duty was to record all answers. In this manner, one person could attend carefully to what was being said and be sure to investigate thoroughly all important questions; and the other person could be sure that everything that was said was carefully recorded. The site visit began with interviews with judges and observations of hearings. The next interviews tended to be with attorneys, referees, state's 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 at first 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, when ICCP 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 the most well-informed and influential people with regard to civil commitment. This was consistent with the ICCP, Phase 1 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 ex-patients and patient advocates, for one example, were interviewed, patients involuntarily hospitalized at the time of the study were not. It is acknowledged that the perspective of the involuntarily hospitalized persons may be one quite different than that of the ex-patients and advocates in the various sites, and one potentially valuable for improvement of the system (even from the 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 in a particularly attractive inquiry which was, unfortunately, beyone the scope of the ICCP. Such omissions do not make the present work less valid, but only incomplete -- an unfortunate flaw of most social research.

Data Analysis and Presentation

A qualitative content analysis was performed on the data collected. 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 ICCP perspective were used to evaluate the civil commitment system in each of the sites in which the field work was done and to shape the provisional guidelines presented in this volume: 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 ICCP 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 analytical framework and its application.

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 provision for treatment. As discussed earlier, this assumes that a valid need for treatment does exist for some people, an assumption consistent with the public values reflected in current commitment laws throughout the country. 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 were considered equally important in the development of the provisional guidelines contained in this volume.

PART II

PREHEARING MATTERS

Contents

INTRODUCTION

This part of the Provisional Guidelines is divided into five chapters corresponding, in a roughly chronological order, to important matters prior to a full-fledged adversarial proceeding and judicial review of the allegations against a respondent facing prolonged involuntary hospitalization. Considered in Chapter One are the means by which involuntary commitment may be started, the various "routes" into the mental health-judicial system, the individuals who may initiate commitment proceedings, and the opportunities and mechanisms for diversion of a respondent from involuntary hospitalization at the initial stages of the process. Chapter Two discusses custody-taking, detention, and the early period of forced hospitalization -- constituting the major participation of law enforcement personnel in the involuntary civil commitment process. It includes a discussion of the mechanisms for authorizing involuntary detention and for notifying the respondent of rights and procedures. This is followed, in Chapter Three, by considerations of the allegations, petitions, and other documents supporting involuntary commitment. Also considered in Chapter Three are the prehearing screening of cases, and the investigation and review of the allegations supporting forced hospitalization.

The last two chapters of this part consider matters and events occurring before the judicial hearing but after a person has been taken into custody and transported to a mental health facility. Mental health examinations supporting prehearing detention are considered in Chapter Four. Finally, in Chapter Five, prehearing diversion and release from involuntary hospitalization are considered. This last chapter also includes a discussion of the opportunities and mechanisms for voluntary admissions, as well as the advantages and disadvantages of preliminary hearings concerning the justification for the reviews of a person prior to a "full" judicial hearing.

Though most commentators consider the judicial hearing to be the centerpiece of the involuntary civil commitment process, the occurrences before such hearings can have pervasive effect on individual cases and on the involuntary civil commitment process as a whole. The ease or difficulty with which involuntary hospitalization can be initiated, and by whom it can be initiated, will determine, to a large extent, the number and types of cases. The civil commitment process may, at times, be overused or abused as a convenient answer to interpersonal, family, and relatively mild social problems. On the other hand, limiting the power to initiate the civil commitment process to designated law enforcement and mental health officials, as is done in many states, may deny ready access to the courts, may restrict the number of involuntary hospitalization cases, and may set high tolerance thresholds for disturbed behavior in the community.

The prehearing occurrences in the involuntary civil commitment process are largely overlooked in legal commentaries, and often are overlooked by the courts. The Institute's report of the study of prehospitalization procedures in Los Angeles County addresses this situation:

> Most commentaries ... begin the review of procedures under the [applicable] Act with a description of the 72-hour emergency hold for screening and evaluation, perhaps with only a brief mention of those persons who are authorized to initiate such holds and of what criteria they are to apply. That is, the commmentaries 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.), thereby failing to draw notice to the prehospitalization procedures, discussed in this chapter, 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. Gauged by what we would estimate is a major impact on the number and types of cases before Department 95, the procedures, described in this chapter, involved in initiating involuntary civil commitment but before actual hospitalization (i.e., referral to community "portals," screening and diversion of cases from involuntary hospitalization, and custody-taking) do not seem to be attended to by court personnel in proportion to their importance.
>
> 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 accord more weight to them. (Involuntary Civil Commitment in Los Angeles County, pp. II-11 to II-12; hereafter Los Angeles).

For many persons, the early occurrences in the involuntary civil commitment process constitute the entire extent of their involvement in the process. Indeed, in some jurisdictions (e.g., Columbus, Ohio) the majority of persons entering the mental health-judicial system as involuntary patients never see the inside of a courthouse. Many persons are screened and diverted to more suitable alternatives (e.g., out-patient treatment, board and care homes, release to the community), many elect to enter a hospital voluntarily, and some are discharged shortly after arrival at the hospital.

In many ways, the prehearing portion of the involuntary civil commitment process is the most complex and yet the most malleable portion of the process. It cuts across the complex interorganizational network of the mental health-judicial system. Also, because commentators and courts have usually not focused on prehearing matters, and because prehearing matters are not now governed by settled law, this portion of the process is open to change.

Courts usually enter a case only after officials of law enforcement agencies, of social service agencies, or of community mental health centers, have made formal decisions regarding commitment of a person. A candidate for commitment may first come to the attention of a law enforcement agency (e.g., after a suicide attempt) or social service agency (e.g., if the person is one of the increasing number of homeless men and women who recently have been released from state psychiatric hospitals and now live on the streets of most major cities). Alternatively, a community mental health center, after a series of failures with outpatient treatment, may decide that one of its clients should be involuntarily committed. Agents of these organizations may effect a person's temporary detention in a mental health facility after some type of prehearing screening, investigation, and review of allegations, petitions, and other documents allegedly supporting involuntary hospitalization.

Prehearing screening, investigation, and review of allegations, is achieved in many jurisdictions by cooperation among mental health practitioners, court personnel, and to a lesser extent, law enforcement personnel. As an allegedly mentally disturbed person is admitted into a hospital, another separable organization -- the mental hospital and its staff -- becomes involved in the case. Law enforcement agencies, having done their job of apprehending, transporting, and detaining a candidate for civil commitment, retreat from the case. Similarly, as long as the person remains an inpatient of the hospital, community mental health centers and social service agencies are removed from the case. Seldom are agents of these organizations drawn back into a case, except indirectly by means of their written records, until the person is released from the hospital. As the case moves closer to a formal hearing, the hospital and the court are dominant. During the formal judicial hearing the court exerts its strongest influence over the case. In brief, the prehearing portion of the commitment process involves complex interorganizational factors, shifting authorities and responsibilities from one organization to another, as a case moves through the involuntary civil commitment process toward judicial hearing.

The dominant problem in involuntary civil commitment, as seen most readily in the prehearing process, no longer seems to be how to effect due process, how best to promote rights of persons involved in the process, nor how to meet minimum legal requirements by means of confrontation in the courts (the problems during the civil rights movement of the sixties). Instead, the dominant problem now seems to be how to achieve linkages, coordination, and cooperation, among the various units in the complex interorganizational network comprising the mental health-judicial system. The adversary system has often wrought procedures that are too complex and onerous to be workable (see Hickman, Resnick, and Olson. Mental Disability Law Reporter, 6(2), 122-130 (1982)). In other words, a litigious approach to involuntary civil commitment, successful in the past, now may give way to cooperation as the best approach to promoting positive change. Similar observations were recently made by Nancy Paschall and Anita Eichler in their examination of advocacy strategies for promoting the rights of mental patients in the context of public policy concerns emerging in the 1980s:

> Far from endorsing ... activist approaches, we would suggest a full exploration of ... cooperative and campaign approaches to consolidate and stabilize advocacy gains achieved through state legislation, administrative rules and court decisions in the past decade. This means local and statewide coalition-building and cooperative, rather than confrontational, interactions with mental health staff. (Mental Disability Law Reporter, 6(2), 121 (1982)).

In most jurisdictions, linkages and cooperative efforts among various agencies involved in the prehearing process (e.g., courts, law enforcement, mental health centers) are, at best, in the formative stages. They are not usually part of settled law and are still malleable. Judges should claim a legitimate interest in the prehearing portion of the commitment process, a portion that greatly influences the types and number of cases before them.

CHAPTER I

INITIATING INVOLUNTARY CIVIL COMMITMENT

Many people having mental aberrations or disabilities never seek professional help or come in contact with the mental health-judicial system. A mentally disturbed person, and those around him or her, may deny the mental aberrations, or learn to cope with them. Alternatively, the person may voluntarily admit him or herself to a psychiatric hospital or seek help from a community mental health center. When none of these voluntary steps is taken, and when people other than the allegedly mentally aberrant person feel that hospitalization is necessary, the involuntary civil commitment process may be initiated.

Considered in this first chapter are three important matters pertaining to initial access to the mental health-judicial system: the "routes" by which the involuntary civil commmitment process is set in motion, the persons who may set it in motion, and the detours or diversions from these routes to treatment alternatives.

THE LAW

Involuntary civil commitment procedures are largely statutory, though landmark federal cases have set important requirements. Discussions of law in this part, and other parts of the Provisional Guidelines, are limited to providing a broad overview of statutory variations in specific areas of the law. The overview is necessarily oversimplified and is not intended as a law review.

Commitment Routes

An allegedly mentally disturbed person may be involuntarily committed in several ways: emergency, judicial, and nonjudicial commitment, and guardianship or conservatorship. In practice, within and among states these categories overlap considerably. The state statutes, however, generally make clear distinctions between them, though they may identify these categories using designations different from those used here.

Most state statutes specifically allow apprehension and emergency detention of persons for whom delay would be inappropriate. Such provisions allow short-term detention (e.g., 72 hours in California) of persons allegedly dangerous to themselves or others due to mental illness. The emergency route can only be utilized by designated individuals (e.g., peace officers, community mental health practitioners, or hospital officials) who must demonstrate probable cause to the admitting mental health facility. Probable cause usually is demonstrated by written application stating the facts and circumstances supporting the allegation that the person should be subject to emergency detention. The emergency route is distinguished from other commitment routes by the necessity for immediate intervention, apprehension, and short-term detention, often involving law enforcement officials, and the absence of

judicial or administrative review. Emergency commitment, perhaps because it is the easiest way to get a person hospitalized against his or her will, and to forego the procedural safeguards encountered in other commitment routes, is the predominant commitment route in many states, especially in big cities. Studies conducted in New York City, Chicago, and Los Angeles, by the National Center's Institute on Mental Disability and the Law, confirm that this route is often used when no emergency actually exists.

In most states that allow emergency commitment, the detention under the emergency provision is temporary and is justifiable only until such time as more deliberate steps toward judicial or other commitment routes can be taken. If such steps are not taken in a specified period of time (three days is typical) the involuntarily detained person must be released.

Judicial (or non-emergency) commitment involves legal personnel throughout its process. It is more deliberately initiated than is emergency commitment. A petition or affidavit is filed alleging that a person should be involuntarily hospitalized. This formally invokes the jurisdiction of the court. Once satisfied that the petition is valid, the court will order the apprehension and prehearing detention of the person. An adversarial hearing is usually held by a judge or a referee (i.e., a court-appointed attorney). Cases are only infrequently heard by a jury (see Part IV, Chapter Four). Statutes in most states provide both judicial and emergency routes to initiate involuntary commitment.

The nonjudicial route minimizes the adversary element, procedural rules, and judicial review. An allegedly mentally disturbed person may be hospitalized by mental health professionals without prior judicial approval. The judiciary plays no part except to examine and ensure the authenticity of the commitment authorization. In contrast to emergency commitment, which also can be initiated without prior judicial approval, the nonjudicial route does not require immediate detention of the person.

Finally, guardianship or conservatorship is a special judicial procedure for assignment of a guardian or conservator, with authority to arrange for care and treatment of an allegedly mentally disabled person. The court may impose restrictions on the guardianship or conservatorship. Although variations of these four initiation routes appear in state statutes, the above summary is representative of these routes. One variation involves the involuntary commitment of a voluntary patient who wants to leave the hospital against the advice of mental health professionals. In such a case, hospital staff apply for emergency involuntary commitment. The only difference from the emergency commitment described above is that the person already is in the hospital.

Authority to Initiate Commitment

Statutes may authorize many persons to initiate commitment proceedings against others, or they may limit this power to a small group of designated officials. Emergency commitment can be effected in most

states only by mental health professionals and law enforcement officials. In Ohio, any psychiatrist, licensed clinical psychologist, physician, or law enforcement official, may initiate emergency involuntary hospitalization by presenting to the hospital a written statement of the facts and circumstances necessitating emergency action. The receiving hospital must admit emergency cases for "observation, diagnosis, care, and treatment." After an examination of the person, the hospital may release the person if, in the opinion of the hospital staff, involuntary hospitalization is no longer necessary.

The power to initiate non-emergency commitment is much less restrictive. In most states, any person with knowledge of the facts or with reliable information may file a petition. Of course, nothing prevents any person from attempting to convince law enforcement officials or mental health personnel to effect the emergency commitment of a person. Although law enforcement officials in most states are also authorized to respond to citizens' requests for emergency hospitalization, they typically are reluctant to respond to such requests.

Detours and Diversions

Once contact is made with a person in need of care and treatment, the course of action by police and mental health workers does not necessarily lead to involuntary hospitalization. Most state statutes give gatekeepers of the emergency commitment route (i.e., police and mental health workers involved in the initiation of the commitment process), the authority to divert the person away from involuntary hospitalization, to alternative treatment modalities. For example, the person may be encouraged to seek out-patient care. Also, he or she may be transported for voluntary admission to a community mental health facility or social service agency.

The policy of the New York City Police Department, for example, encourages police officers to negotiate, with the assistance of a person's family or friends, with public or private mental health agencies to resolve an emergency situation. In Arizona, police officers will not take a person possibly meeting the emergency detention criteria into custody until they have telephoned staff of the medical facility likely to receive the person. To confirm that the person is likely to warrant emergency detention, the officers communicate the person's circumstances and behaviors to mental health officials. These procedures encourage diversion to less restrictive treatment alternatives for those persons in need of help but not necessarily requiring involuntary in-patient hospitalization.

In some states, diversion from forced hospitalization may occur early in the commitment process because of a requirement that petitions be accompanied by a certificate declaring that one or more medical or mental health professionals supports the petition (e.g., Illinois, Ohio, Wisconsin, Oklahoma, New Jersey, Idaho). The certification requirement primarily is intended to protect the individual's liberty interests and to prevent abuse of the commitment process. Opportunity for diversion from involuntary hospitalization is provided by such requirements, however, because mental health professionals may better assess the person than would the petitioner.

GUIDELINES

Prehearing matters may have more bearing on the equity, effectiveness, and efficiency of a commitment system, and on the public's satisfaction with the system, than the events at any other stage in the commitment process. Systems that provide for a prompt, reliable, and thorough screening procedure, and a diversion of cases at the earliest stages, protect both the liberty interests of the respondents, and the pocketbook of the taxpayer. The guidelines in this chapter suggest that involuntary civil commitment prehearing matters are an important aspect of the process, that the prehearing process is malleable without legislative reform, that responsibility for its implementation is diffused, and, most importantly, that the courts (i.e., judges, court administrators, and managers) should take this initial stage of commitment into their purview and should take shared responsibility for its monitoring and regulation.

Commitment Routes, Detours, and Diversions

GUIDELINE II-A. (1) REGARDLESS OF THE COMMITMENT ROUTE -- EMERGENCY, JUDICIAL, NON-JUDICIAL, OR GUARDIANSHIP -- ENTRY INTO THE MENTAL HEALTH-JUDICIAL SYSTEM SHOULD BE MONITORED AND REGULATED BY AUTHORIZED "GATEKEEPERS" AT DESIGNATED "PORTALS" IN THE COMMUNITY. THESE GATEKEEPERS SHOULD BE EMPOWERED AND QUALIFIED TO INITIATE INVOLUNTARY CIVIL COMMITMENT ALONG ITS VARIOUS ROUTES OR TO DIVERT CASES TO LESS RESTRICTIVE ALTERNATIVES.

(2) COMMUNITY PORTALS, SERVING AS SCREENING AGENCIES WITHIN THE COMMUNITY, SHOULD REVIEW AND INVESTIGATE APPLICATIONS FOR INVOLUNTARY COMMITMENT, AND, IF APPROPRIATE, SHOULD DIVERT CASES TO LESS RESTRICTIVE TREATMENT ALTERNATIVES (AS PRESCRIBED IN GUIDELINES II-S THROUGH II-U). SCREENING REPORTS SHOULD BE FILED WITH THE COURT.

GUIDELINE II-B. JUDGES, COURT ADMINISTRATORS, AND COURT MANAGERS SHOULD INFLUENCE THE POLICIES OF PORTAL AGENCIES (E.G., POLICE DEPARTMENTS, SHERIFF'S DEPARTMENTS, MENTAL HEALTH DEPARTMENTS, COMMUNITY MENTAL HEALTH AGENCIES, AND HOSPITALS) TO FOSTER A UNIFORM, UNDERSTANDABLE, AND CONTROLLABLE PROCEDURE FOR INITIATING AND SCREENING INVOLUNTARY COMMITMENT CASES.

GUIDELINE II-C. THE COURT SHOULD REVIEW, MONITOR, AND REGULATE, THE ACCESS TO THE MENTAL HEALTH-JUDICIAL SYSTEM BY THE VARIOUS INVOLUNTARY CIVIL COMMITMENT ROUTES.

GUIDELINE II-D. JUDGES AND ATTORNEYS SHOULD BE THOROUGHLY FAMILIAR WITH THE METHODS AND OPERATIONS OF

THE COMMUNITY PORTALS AND GATEKEEPERS REGULATING INVOLUNTARY CIVIL COMMITMENT CASES.

Comment

In most jurisdictions, the practices in the initial stages of the commitment process evolved in the absence of rigorous reviews of their equity, efficiency, and effectiveness, except for occasional reviews by the federal judiciary. The administration of agency linkages and cooperation, and the management of resources from various units of the mental health-judicial systems, have been largely left to expediency. In Chicago, Los Angeles, and New York City, for example, although non-emergency routes are provided by statute, access to involuntary commitment is usually limited to the emergency route. Because non-emergency routes are expensive, time-consuming, and burdensome to an already strained system, their use is discouraged by court personnel and mental health practitioners. Because the emergency route is the quickest way to get someone into the hospital, with the least amount of red tape, it is likely that many persons involuntarily hospitalized via this route are not the emergency cases envisioned by legislators.

Guidelines II-A through II-D propose that the courts take control of the initiation process. The arrangements of community portals for entry into the mental health-judicial system are malleable. Without legislative reform, the courts can regulate the gatekeeper's practices in the initial stages of commitment. Typically, several units of the mental health-judicial system are involved in initiating involuntary civil commitment: law enforcement agencies, community mental health centers, hospitals, and courts. Responsibility for a particular case shifts back and forth from one unit to another as a case proceeds through the system, until it settles largely with a court during judicial hearing. The courts are in the best position to effect cooperation among agencies, thereby achieving the maximum design and fair implementation of community portals and gatekeepers.

The identification and configuration of community portals, and the precise confluence of cases through those portals, should be locally determined. In Arizona and occasionally in North Carolina (see Involuntary Civil Commitment in Winston-Salem, p. 32 (1982); hereafter Winston-Salem), peace officers confer with hospital staff by telephone before proceeding toward detention and involuntary hospitalization of a person whom they have apprehended, and, thereby divert inappropriate cases from hospitalization. In Columbus, Ohio, a mental health review unit of the probate court works cooperatively with hospitals and local community mental health centers to funnel all involuntary civil commitment cases through the community centers for review and screening (see Part VII, Chapter Two). In nearby Dayton, Ohio, a court liaison, employed by the court but located in a community mental health center, screens all petitions for involuntary civil commitment, diverting many cases from forced hospitalization. Finally, in Los Angeles, mobile psychiatric emergency teams -- consisting of community mental health workers and the police -- serve as gatekeepers to the mental health-judicial system.

At a minimum the arrangement of community portals and methods of gatekeepers should:

(a) Be visible, accessible, and manageable by the courts, working in cooperation with agencies involved in the initial stages of the commitment process;

(b) be monitored, if not regulated, by the courts;

(c) provide all legal safeguards mandated by statutes;

(d) be an extension or an adaptation of existing service delivery systems now accessible to the public (e.g., community mental health centers or court clinics);

(e) provide prompt access to mental health facilities without undue delays in emergency treatment and care;

(f) provide fair, prompt, and reliable decisionmaking about involuntary hospitalization and diversion alternatives;

(g) facilitate diversion of the maximum number of cases from involuntary hospitalization and the mental health-judicial system;

(h) be fair, effective, and efficient; and finally,

(i) avoid onerous complexity.

The Gatekeepers

GUIDELINE II-E. (1) GATEKEEPERS SHOULD BE MENTAL HEALTH PROFESSIONALS, OR COURT PERSONNEL WORKING IN COOPERATION WITH MENTAL HEALTH PROFESSIONALS, EXPERIENCED IN THE DIAGNOSIS OF MENTAL ILLNESS AND FACILE IN APPLYING THE LEGAL, PSYCHOLOGICAL, AND SOCIAL CONSTRUCTS USED IN MAKING DECISIONS CONCERNING DETENTION PURSUANT TO INVOLUNTARY HOSPITALIZATION, RELEASE, AND ALL INTERMEDIATE ALTERNATIVES.

(2) GATEKEEPERS SHALL SERVE AS SCREENERS, OR WORK IN CLOSE COOPERATION WITH SCREENERS, TO CAUSE REVIEW AND INVESTIGATION OF COMMITMENT APPLICATIONS, AND THE SCREENING AND DIVERSION OF CASES FROM COMPULSORY HOSPITALIZATION AS DESCRIBED IN GUIDELINES II-S THROUGH II-U.

GUIDELINE II-F. GATEKEEPERS SHOULD HAVE THE AUTHORITY TO ORDER INVOLUNTARY DETENTION AND TO REQUEST AMBULANCE OR POLICE ASSISTANCE FOR TRANSPORTING RESPONDENTS TO AND FROM APPROPRIATE MENTAL HEALTH FACILITIES.

Comment

The decision by mental health personnel or police to initiate the involuntary civil commitment process, in most jurisdictions, invariably causes an individual some curtailment of liberty, loss of rights, and stigma of being labeled "mentally ill." Thorough mental health screening and evaluation, and judicial review of a case before detention and forced hospitalization, has remained a matter of theory. "The majority of courts addressing the issue of whether there is a right to a probable-cause hearing in civil commitment proceedings, implicitly acknowledge the need for a hearing before a non-emergency admission is made, but primarily address the arguments for or against a prompt probable-cause hearing soon after the initial detention" (Mental Disability Law Reporter, 5(4), 290 (1981); emphasis added).

The decisions regarding entry into the mental health-judicial system entail more than determining whether the psychological criteria for involuntary civil commitment, as defined by statutes, have been met in particular cases. Good decisions are based on knowledge of conditions in state institutions, availability of less restrictive alternatives for particular classes of persons (e.g., gravely disabled, those harmless to others, elderly persons), and the budgetary restraints on the units of the mental health-judicial system likely to be involved in the case. They also entail a good understanding of linking the courts and other units of the mental health-judicial system in cooperative strategies.

Qualifications appropriate for a gatekeeper may trace the qualifications of a "mental health review officer," as proposed in a suggested statute on civil commitment presented in 1977 by the Mental Health Law Project in Washington, D.C.:

> "Mental health review officer" means a person designated as such by [the county mental health authority or human rights committee] who was actively engaged in the treatment and diagnosis of mental disorders during at least two of the three years immediately preceding such designation and who is:
>
> (a) a psychiatrist;
>
> (b) a psychologist with a doctoral degree from an accredited clinical program and such experience in the treatment and diagnosis of serious mental disorders as is required under rules and regulations adopted by the Commissioner; or

(c) in counties in which sufficient persons having the qualifications required under the preceding subsections (a) and (b) are, with the approval of the Commissioner, found to be unavailable, a person with the following qualifications who has such experience in the treatment and diagnosis of serious mental disorder as is required under regulations adopted by the Commissioner:

(i) an earned graduate degree in psychology from an accredited clinical program;

(ii) a social worker with an earned graduate degree in social work with field training in a psychiatric facility from an accredited program; or

(iii) a registered nurse with a graduate degree in psychiatric nursing from an accredited program.

The "mental health review officer" is a mental health professional, preferably independent of evaluation and treatment facilities, whose functions include the screening of petitions for evaluation and various preliminary or short-term determinations in the course of commitment proceedings, evaluation and treatment. A provision to avoid conflict-of-interest situations in individual situations is included in the definition. (Suggested statute on civil commitment. Mental Disability Law Reporter, 2(1), 132, 134 (1977)).

Guidelines II-5 and II-6 suggest the identification of gatekeepers that function on the threshold of involuntary civil commitment much as judges function during hearings later in the commitment process. They should be knowledgeable and talented individuals, capable of making, and empowered to implement, decisions about release, involuntary confinement, and all the options between those extremes, in the context of legal requirements, mental health practices, social values, and resource allocations from various sources within the mental health-judicial system. Given these demands on gatekeepers, teams comprised of two or more individuals from different parts of the system may need to function cooperatively to do the job.

CHAPTER TWO

CUSTODY AND DETENTION

In common practice, when involuntary civil commitment proceedings are initiated, the allegedly mentally ill person is taken into custody and involuntarily detained, without a thorough investigation and review of the allegations supporting the deprivation of liberty. This practice is most clearly evident along the emergency commitment route where swift action is justified to prevent serious harm. Typically, a person who may be acting in a bizarre manner that poses a threat to him or herself, or to others, is picked up by the police and quickly whisked away to a mental health facility with a minimum of red tape. Common sense and expediency, rather than the rule of law, prevail.

As discussed in the previous chapter, most states have different procedures, in statute if not in practice, for emergency detention and treatment, evaluation and care, and for longer-term, non-emergency commitment. In emergency cases, custody-taking and involuntary detention usually precede any deliberate and thorough review of the grounds for commitment. In non-emergency cases, at least some review of the allegations and evidence supporting involuntary hospitalization is made. In this chapter, custody-taking and detention procedures are considered. Considered in the next two chapters will be matters which must be shown to justify these procedures and, thereby, prolong involuntary hospitalization, and matters of investigation and screening of cases prior to involuntary hospitalization. In practice, however, except in commitment along the emergency route, some investigation and review of the allegations and evidence supporting forced hospitalization, as well as some screening and diversion of cases, may and should occur before custody-taking and involuntary hospitalization.

THE LAW

This overview of statutory and case law variations considers the grounds for custody and detention, and how those grounds differ from the substantive criteria for involuntary commitment. Also considered are the procedures for custody-taking pursuant to involuntary hospitalization, and the procedures for prehearing detention.

Grounds for Custody and Detention

State statutes vary in the degree to which the grounds for custody and detention differ from the substantive criteria for involuntary commitment (e.g., mental illness, dangerousness, grave disability; see Part IV, Chapter Three). These may be the same or totally different. Some states require that the same substantive criteria be met at the time of initial detention and at later stages of the commitment process, except that a lower burden of proof is required at the time of custody and detention.

The majority of state statutes require that custody and detention of a person meet standard criteria qualified by a standard of proof lower than the "clear and convincing" standard, the generally accepted, and constitutionally required minimum standard for involuntary commitment (see Part IV, Chapter Three). For example, statutes in Iowa and Ohio require sufficient "reason to believe," "reasonable grounds," or "probable cause," to indicate that the person meets the criteria. The statutes of a minority of states providing for emergency detention require grounds quite different than those for protracted commitment. In New Jersey, for example, involuntary detention is allowed if a temporary court order for judicial commitment is not obtainable. The New York emergency admission statute provides that a person may be involuntarily hospitalized for up to 15 days if he or she is alleged to have "a mental illness for which immediate observation, care, and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others." "Likelihood to result in serious harm" is defined as "(1) substantial risk of physicial harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself, or (2) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm" (McKinney's Consol. Laws of N.Y. Annot., Mental Hygiene Law, Section 9.39 (1978)).

Taking a Person Into Custody

Some statutes give very little direction concerning how a respondent should be taken into custody, while others are quite specific. Provisions might include prescribed procedures, such as who is authorized to "hold" the person prior to mental health examination, treatment, or judicial hearing, the timing of custody-taking, the place of detention, and other details such as the mode of transportation. Statutes often require that during the custody-taking, or at the time of detention, respondents must be notified of their rights.

Who may take legal custody of a respondent, regardless of the commitment route, is restricted in most states to those individuals authorized to effect emergency commitment (i.e., mental health professionals and law enforcement officials). A representative list includes peace officers (e.g., California, Illinois, Indiana, Ohio, New York), sheriffs or deputies (e.g., Ohio, Illinois), law enforcement officers (e.g., North Carolina), psychiatrists or licensed clinical psychologists (e.g., Ohio), health officers, (e.g., Texas, Idaho), and facility directors (e.g., Idaho). The timing of custody-taking may be immediate (e.g., Ohio), upon receipt of a warrant (e.g., Texas), or within twenty-four hours of court order (e.g., North Carolina). The immediate destination may be prescribed as the nearest hospital (e.g., Ohio, Idaho, Texas), a designated place of mental health examination or hearing (e.g., Illinois), or a place designated by a director of community services.

Some statutes specify other details regarding custody-taking and detention procedures: the person taking the respondent into custody

should wear plain clothes (California, North Carolina); transportation of the respondent should be in unmarked cars (California); family or friends may transport the respondent in their personal cars with permission of the court (North Carolina); reasonable force may be used (North Carolina); concern should be given to protection of a respondent's property during custody-taking and involuntary detention (Ohio, California); and, finally, every reasonable and appropriate effort should be made to take a respondent into custody in the most humane, least disruptive, and least conspicuous manner (California, Ohio). In some places, these requirements are specified in applications or other documents supporting involuntary commitment, or in police instructions for handling allegedly mentally ill persons (see, e.g., Appendices to Involuntary Civil Commitment in Columbus, Ohio, hereafter Columbus, and New York).

Another prehearing concern is the prompt notification of rights to the respondent. Federal courts have recognized the individual's important stake in receiving prompt, adequate notice of his or her rights in civil commitment proceedings. "Since effective notice is a prerequisite to the exercise of an individual's other due process rights, mandatory notice must itself be a requirement of due process." (Doremus v. Farrell, 407 F. Supp. at 515 (D. Neb. 1975); see also, Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972); Bell v. Wayne, 384 F. Supp. 1085 (E.D. Mich. 1974)). There is disagreement, however, concerning what notice is constitutionally adequate. The important issue is whether notice is given at custody-taking or at some later point in the proceedings. Other matters dealt with in statutes are the methods and contents of the notice, and the person or persons responsible for giving the notification.

Most states require notification of rights but differ in stating when, how, and by whom, such notification must be given. The New York law requires that immediately upon the respondent's admission to a hospital, or conversion to a different status (e.g., from voluntary to involuntary status), the hospital director must inform the respondent in writing of his or her status, of his or her rights, and of the availability of New York's Mental Health Information Service (see New York, p. III-6). In Iowa, an attorney assigned to the respondent is required to explain available rights, as well as the nature and likely consequences of the proceedings. Several states (e.g., Illinois, Massachusetts, New Jersey) require that notification be made in understandable language. The California law is particularly specific:

> ... [E]ach person who is taken into custody for 72-hour holds [for emergency treatment and evaluation] is to be given the following information by the authorized person who takes 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) the fact that the custody-taking is not a criminal arrest;

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

(4) the fact 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, the fact that he or she may bring along a few personal items, make a telephone call, and leave a message for friends and 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. (Los Angeles, pp. II-9, 10).

State statutes generally require that notices of respondents' rights contain three types of information: general, legal, and treatment. The following representative listing of elements (rights, explanations, and duties) contained in statutory notification requirements conforms generally to these broad categories of information requirements:

Personal items (California)
Access to telephone or opportunity to leave written note (Ohio, California)
Interpreter (California)
Communication with mental health officials (New York)
Same protections and rights of persons already committed (Idaho)
Reasonable number of telephone calls to reach attorney, physician, or licensed clinical psychologist (Ohio)
Statement of reason or purpose for detention (California, New Mexico)
Clear and concise statement of legal status (Illinois)
Hearing within a specified number of days (Iowa, New Mexico, New York, Massachusetts)
Hearing before a judge (California)
Jury trial (Oklahoma)
Probable cause or preliminary hearing (Ohio, Connecticut, Massachusetts)
Presence at hearings (Massachusetts, Iowa)
Assistance of counsel (California, Ohio, Massachusetts)
Statement of maximum length of detention (California)

Copy of application or petition (Massachusetts)
Examination by a mental health professional (Massachusetts, Iowa, California)
Silence during examination (Illinois)
Statement of duty to remain in jurisdiction (Iowa)
Statement of time and place of mental health examination (Iowa)
Necessary and appropriate treatment (New Mexico, California)
Refusal of medication (Illinois)
Evaluation and treatment (California)
Availability of medical and psychiatric assistance (Ohio)
Independent mental health examination (Massachusetts, New Mexico, Iowa, Ohio)

Prehearing Detention

This section addresses matters pertaining to detention of a respondent pending the commitment hearing or a formal decision to commit. Statutory considerations include the place of detention, the maximum period of detention, the authority to transfer custody, and the notice of detention required to be given to concerned parties.

Statutes show a clear legislative preference for the use of a mental health facility as the place of prehearing detention. To some extent, the place of detention varies according to the commitment route taken; typically, the more urgent the situation, the more restrictive the permitted placement. Most states, however, permit prehearing detention in a variety of settings. The following are examples of permitted settings:

Respondent's home (under "appropriate supervision") (North Carolina)
In custody of relative, friend, or other suitable and willing person, subject to court-ordered restrictions (Iowa)
Community mental health center (North Carolina)
Not in a jail or other penal facility (North Carolina)
Evaluation facility (New Mexico)
Facility for mental health treatments (Massachusetts)
Rest or nursing home (Ohio)
Mental health hospital designated by county official (New Jersey)
Nearest hospital or public or private community facility suitably equipped and staffed (Iowa)
Veteran's Administration Hospital (New York)
In "actual emergency," when no other secure facility is accessible, in jail for no more than 24 hours (Iowa)
Jail in extreme emergency (New Mexico)
Jail if no less restrictive alternative available (Ohio)

Statutes typically indicate quite clearly the maximum period for which a respondent might be detained prior to judicial review (or the opportunity for review in those states not automatically providing such review). The review might be in the form of a probable cause or preliminary hearing (following which a respondent might be held for a certain period of time pending a "full" commitment hearing), a full commitment hearing, or a habeas corpus proceeding. Some statutes articulate a maximum period for which a respondent might be detained pending a mental health examination. A number of state statutes indicate how the maximum period is affected by weekends, holidays, and other days when courts are not in session. As with many of the procedures discussed, the maximum periods specified in statutes vary depending on the commitment route.

The listing below is representative of statutorily defined maximum periods of prehearing detention, and the events in the commitment process by which these periods are fixed. The times presented are calculated as true maximums, to the extent that such calculations are possible given the statutory information available; continuances are not considered.

Eight hours until magistrate's screening; 48 hours from magistrate's order until hearing (Iowa)
72 hours until probable cause hearing (Virginia)
24 hours until medical examination and certificate, then five days until hearing (Illinois)
Three days until filing of affidavit or temporary order of detention (Ohio)
Two days from request of habeas corpus hearing (California)
Five days from request of hearing (New York)
24 hours until examination, then ten days until hearing (North Carolina)
72 hours until probable cause hearing, then five days until judge trial or ten days until jury trial (Washington)
Three days until probable cause hearing (if requested), then thirty or forty-five days (depending on route) until hearing (Ohio)
Seven days from temporary commitment or a physician's certificate until hearing (New Jersey)
Twenty days from date of admission, then judicial route (New Jersey)

Although most state statutes fail to address transfer of custody during prehearing detention, several statutes do specify who has the authority to effect such transfers. For example, in New Jersey, the commissioner of the receiving institution or agency has authority to transfer custody. In Iowa and Idaho, the court may exercise such authority upon request of the respondent's attorney.

Most statutes clearly specify who should receive notice of the respondent's detention, the official responsible for giving such notice,

and how soon after detention the notice must be given. A few states require that the respondent be given notice of his or her detention, although this requirement appears peculiar. Generally, statutes specify that notice of the respondent's detention be given to the nearest relative, the attorney for the respondent or the public defender, or the guardian, mental health advocacy group, appropriate state agency, district or county attorney, friend, or other persons designated by the respondent or by the Department of Mental Health. The official responsible for giving such notice is usually an officer of the court, the head of a hospital or other facility, the Director of Community Services, a police officer, or a designated mental health officer. The timing of notice is usually fixed by the time of custody or detention, the beginning of evaluation or treatment, admission to a mental health facility, the appointment of an attorney, the time of certification, or the date of hearing. For example, Idaho and Ohio require notice upon taking the respondent into custody. Arizona requires notice upon evaluation or treatment; Michigan and Illinois require notice within 12 and 24 hours of admission respectively; finally, New Jersey and Indiana require that notice be given five days and ten days before hearing, respectively, for respondents entering the mental health-judicial system via the judicial route.

GUIDELINES

The guidelines in this chapter reflect general themes which pervade this part of the Provisional Guidelines: (1) the prehearing process of involuntary civil commitment should be more visible to the courts; (2) the courts should claim a proper interest in prehearing matters because they directly effect how the courts keep their house; and, (3) the building of cooperative strategies is necessary to effect improvements in the involuntary civil commitment process. These themes are particularly relevant to custody and detention because it is almost invariably only after custody, detention, and at least short-term commitment of a respondent, that the courts address questions concerning due process and the appropriateness of involuntary hospitalization.

Guidelines in this chapter and elsewhere in this document are aimed at aspects of the involuntary civil commitment process that are malleable and can be directly influenced by judges, court administrators and managers. Generally speaking, action need not be contingent on legislative reform.

Differing Grounds for Police and Gatekeepers

GUIDELINE II-G. THE GROUNDS USED BY LAW ENFORCEMENT OFFICIALS FOR TAKING CUSTODY OF A RESPONDENT IN EMERGENCY CIRCUMSTANCES MAY BE DIFFERENT FROM THE GROUNDS PRESCRIBED IN STATUTE FOR DETENTION PURSUANT TO INVOLUNTARY COMMITMENT. LAW ENFORCEMENT OFFICIALS SHOULD USE A COMMON SENSE MODEL OF MENTAL ILLNESS, BUILT ON EXPERIENCE, AND ON THRESHOLDS OF DANGEROUSNESS AND DISABILITY DIFFERENT THAN THOSE WHICH PRACTITIONERS IN THE MENTAL HEALTH-JUDICIAL SYSTEM FOLLOW PURSUANT TO MENTAL HEALTH LAWS.

GUIDELINE II-H. THE GROUNDS WHICH GATEKEEPERS USE FOR INVOLUNTARY DETENTION IN A MENTAL HEALTH FACILITY SHOULD BE BASED ON THE PSYCHOLEGAL CRITERIA PRESCRIBED IN STATUTE.

Comment

Peace officers use, more or less, a common sense model of mental illness and quite different thresholds for custody-taking than those that may be prescribed in or suggested by statutory criteria for commitment.

> There are certainly some people who behave so inexplicably irrationally, so crazily, that society is perhaps warranted in believing that something is "wrong" with such persons. Identification of these persons, rather than being a scientific matter, requires a social, moral, and legal assessment that these people are fit subjects for preventive detention because they behave in an inexplicably irrational manner betokening lack of fundamental autonomy. (Morse, S.J. In C.A.B. Warren, The Court of Last Resort: Mental Illness and the Law. Chicago: University of Chicago Press, 1982.

Police department policies and procedures are aimed at isolation and containment of mentally disturbed people (see New York, p. A-3) and at public safety, not at mental health treatment and care. Rather than forcing law enforcement officials to conform their operations to psycholegal constructs (e.g., dangerousness) that continue to be the subject of debate -- an action which may undermine cooperation between law enforcement agencies, the courts, and the mental health community -- it may be better to acknowledge differences and to build cooperative strategies. Gatekeepers, on the other hand, should be very familiar with the statutory criteria for commitment, and should be able to apply the elements of those criteria to decisions about detention, release, and diversion of cases in the context of legal requirements, mental health practice, and the realities of the allocation of scarce resources.

Guidelines II-G and II-H suggest that police and gatekeepers have different purposes, and different thresholds that must be overcome, before action is taken. Police work toward the isolation and containment of a mentally disturbed person and toward the maintenance of public safety. Gatekeepers are concerned primarily with treatment and care. These different grounds for action -- one based in common sense and concern for public safety, and the other in law and parens patriae -- may prove quite compatible. Moreover, this distinction acknowledges fundamental differences in the goals and methods of police operations and of gatekeepers.

Custody-Taking

GUIDELINE II-I. (1) PROCEDURES FOR INITIATING INVOLUNTARY CIVIL COMMITMENT THROUGH COMMUNITY PORTALS

AND BY MEANS OF GATEKEEPERS SHOULD NOT BE UNDULY TIME-CONSUMING OR BURDENSOME TO LAW ENFORCEMENT OFFICIALS WHO TAKE INITIAL CUSTODY OF RESPONDENTS.

(2) CUSTODY-TAKING PEACE OFFICERS SHOULD NEED TO WORK ONLY WITH A LIMITED NUMBER OF COMMUNITY PORTALS AND GATEKEEPERS TO EFFECT TRANSFER OF RESPONSIBILITY FOR A RESPONDENT PURSUANT TO INVOLUNTARY CIVIL COMMITMENT.

(3) ALTHOUGH IT MAY BE VERY IMPORTANT FOR ADMITTING FACILITY STAFF TO SPEAK WITH THE CUSTODY-TAKING OFFICER, PEACE OFFICERS SHOULD NOT BE REQUIRED TO REMAIN WITH A RESPONDENT TO AWAIT THE RESULTS OF MENTAL HEALTH EXAMINATIONS.

(4) IF A RESPONDENT IS RELEASED AFTER MENTAL HEALTH EXAMINATION, LAW ENFORCEMENT AGENCIES SHOULD NOT BE RESPONSIBLE FOR RETURNING THE RESPONDENT TO THE PLACE OF CUSTODY-TAKING.

Comment

As indicated earlier, prehearing operation methods have evolved based on expediency and common sense. Practices have departed sharply from procedures prescribed in statute, especially when those procedures prove to be burdensome. If mental health personnel accord peace officers little respect when the peace officers arrive at a mental health facility, the peace officers will be less likely to return to that facility. Their threshold for intervening in emergency cases may be heightened if they are forced to "shop around" for emergency mental health treatment, to "justify" their actions to unsympathetic hospital staff, and to remain in the hospital with the respondent for hours until he or she is examined, and if they are regarded as a taxicab service to transport mentally disturbed persons. The average time required by a police officer to "process" an emergency commitment in New York City is about three hours, an obviously great amount of police time for a department ravaged by strained resources (see New York, p. III-2). The amount of time required for dealing with mentally disturbed persons, absent a crime, may be prohibitive for some police departments. A small police force outside of Columbus, Ohio, simply transports the person beyond the boundaries of its jurisdiction, and warns the person not to return.

Cooperation between courts, mental health facilities, and law enforcement agencies, is required to implement Guideline II-I. For example, a "no decline policy," like that developed in Chicago (see Chicago, p. 37) may have to be developed between police, gatekeepers, and receiving facilities, to relieve police of the burden of "shopping" for a place willing to take the person in their custody. To reduce time police are required to remain with a respondent, facility staff should develop a standard set of questions designed to elicit from peace officers information about the respondent's behavior during custody-taking that might be helpful to the mental health examination. These questions

should be available to police departments so that they may incorporate them into department operations policy. Judges should encourage such cooperation.

> GUIDELINE II-J. IN RECOGNITION THAT RESPONDENTS FACING INVOLUNTARY CIVIL COMMITMENT ARE ONLY ALLEGED TO BE MENTALLY DISTURBED AND HAVE NOT BEEN CHARGED WITH COMMISSION OF CRIMINAL ACTS, THEIR APPREHENSION AND CUSTODY-TAKING SHOULD BE IN THE MANNER LEAST CONSPICUOUS, AND LEAST DISRUPTIVE TO THE RESPONDENT'S LIFE. CUSTODY-TAKING PEACE OFFICERS MUST MAKE EVERY ATTEMPT TO SAFEGUARD THE RESPONDENT'S PERSONAL PROPERTY.
>
> GUIDELINE II-K. COURTS SHOULD ENCOURAGE POLICE DEPARTMENTS TO DEVELOP SPECIAL MENTAL HEALTH UNITS, CAPABLE OF 24-HOUR, RAPID-RESPONSE CRISIS INTERVENTION. SUCH UNITS SHOULD WORK CLOSELY AND COOPERATIVELY WITH COMMUNITY MENTAL HEALTH-JUDICIAL SYSTEM GATEKEEPERS.
>
> GUIDELINE II-L. TRAINING SHOULD BE AVAILABLE FOR LAW ENFORCEMENT AGENCIES CONCERNING: THE NATURE AND MANIFESTATIONS OF MENTAL HEALTH DISORDERS, HOW TO COMMUNICATE WITH AND HANDLE MENTALLY DISORDERED INDIVIDUALS AND, IMPORTANTLY, COMMUNITY RESOURCES AND PORTALS TO WHICH ALLEGEDLY MENTALLY ILL INDIVIDUALS MAY BE TAKEN OR REFERRED PURSUANT TO INVOLUNTARY HOSPITALIZATION OR SOME LESS RESTRICTIVE ALTERNATIVE.

Comment

Although justification may exist for keeping the initiation of the judicial hospitalization procedures a relatively formidable undertaking for the general public, no such justification exists for initiation of emergency hospitalization procedures undertaken by police and gatekeepers. Onerous complexity, unclear responsibilities, misunderstandings, and lack of cooperation between law enforcement agencies, mental health services, and courts, characterize the custody-taking part of the commitment process throughout much of the country. The above guidelines propose cooperation between peace officers and gatekeepers to make emergency commitment a coordinated effort that is fair and minimally disruptive to the respondent, and does not unduly impair the effectiveness of law enforcement agencies. In New York City, only about one-half of the over 7,500 respondents transported to mental health facilities each year for emergency hospitalization are allowed admission pursuant to involuntary commitment (New York, III-2, II-11). At least some of the respondents diverted from or rejected for hospitalization, and the associated waste of resources, may have been avoided by training of peace officers and by cooperation between peace officers and gatekeepers. The development of special mental health units in police or sheriff's departments is an accommodation by law enforcement agencies to the special needs of respondents and of the mental

health-judicial system. Similarly, gatekeepers in community portals should meet police halfway. Gatekeepers should be knowledgeable about police work, and sensitive to its needs and constraints. Ideally, particular units of law enforcement agencies should develop special working relationships with a limited number of gatekeepers and community portals.

Guideline II-L suggests that training programs and supporting educational materials be available to law enforcement agencies. A simple and inexpensive training program, for example, might involve informal briefings among peace officers, special mental health units of law enforcement agencies, and gatekeepers employed by community mental health centers. Training of peace officers could also be accomplished through written memoranda prepared by a special committee of individuals from law enforcement agencies, from community mental health centers and hospitals serving as community portals, and from courts. For example, court personnel and gatekeepers could contribute valuable information from a legal perspective regarding the initiation of the civil commitment process; community mental health center gatekeepers could provide valuable information regarding procedures for communicating with community portals; and, finally, members of a special police unit could provide practical information regarding the mechanics of custody-taking. More ambitious projects, such as training sessions, simulations, and workshops, also could be used.

> GUIDELINE II-M. (1) THE PERSON TAKING A RESPONDENT INTO CUSTODY, SHOULD GIVE THE RESPONDENT THE FOLLOWING INFORMATION: (a) THE NAME, PROFESSIONAL DESIGNATION, AND AGENCY AFFILITATION OF THE PERSON TAKING CUSTODY; (b) THE NATURE AND CONSEQUENCES OF THE CUSTODY-TAKING, INCLUDING THAT IT IS NOT A CRIMINAL ARREST; (c) THAT THE PERSON IS GOING TO BE TRANSPORTED BY PARTICULAR MEANS (E.G., AMBULANCE, POLICE CRUISER, PERSONAL CAR) FOR INVOLUNTARY EXAMINATION, TREATMENT, OR CARE, BY MENTAL HEALTH PROFESSIONALS AT A MENTAL HEALTH FACILITY IDENTIFIED BY NAME; (d) THAT LEGAL RIGHTS WILL BE EXPLAINED BY THE GATEKEEPER AT THE MENTAL HEALTH FACILITY TO WHICH THE PERSON IS TAKEN; AND, (e) IF THE PERSON IS TAKEN INTO CUSTODY NEAR HIS OR HER RESIDENCE, THAT HE OR SHE MAY BRING ALONG A FEW PERSONAL ITEMS, MAKE ONE TELEPHONE CALL, AND LEAVE APPROPRIATE MESSAGES FOR FRIENDS OR FAMILY MEMBERS.
>
> (2) THE AUTHORIZED PERSON SHOULD GIVE THE INFORMATION IN (1) ORALLY. IN ADDITION TO INFORMING THE RESPONDENT THAT HIS OR HER LEGAL RIGHTS WILL BE EXPLAINED BY GATEKEEPERS, THE AUTHORIZED PERSON SHOULD GIVE THE RESPONDENT, AT THE TIME OF CUSTODY-TAKING, WRITTEN NOTICE OF HIS OR HER LEGAL RIGHTS.
>
> (3) ORAL AND WRITTEN STATEMENTS REGARDING LEGAL RIGHTS, PROTECTIONS, AND EXPLANATIONS OF PROCEDURES, PROVIDED TO EACH RESPONDENT AT THE TIME OF CUSTODY-TAKING, SHOULD BE IN SIMPLE LANGUAGE.

Comment

An explanation of rights as required by law may not completely explain to a respondent the nature and consequences of the involuntary civil commitment process. Respondents often are not adequately informed about the entire process, despite many attempts to inform them of their legal rights. Some commentators suggest that sufficient comprehension may be beyond the capacity of many respondents. Many mental health personnel consider such explanations of legal rights to be a waste of time, believing that respondents are mostly too ill, anxious, and generally too confused to comprehend the explanations. They suggest that overwhelming respondents with what may be perceived as nothing but confusing papers and verbal gibberish merely exacerbates an already strained situation.

Presenting a person with a piece of paper setting forth his or her legal rights, when the paper is meaningless to the person, may be a pointless and ritualistic gesture. For respondents capable of understanding, however, the notice and explanation are essential to provide them an opportunity to protect their rights. Guideline II-M provides a format for a relatively simple, standardized notice and explanation procedure. Because at the time notice and explanation should be given, it may not yet be determinable whether a respondent is capable of understanding, the same procedure should be used for all respondents. Once a standardized procedure is developed, implementation in each case should be relatively simple.

Prehearing Detention

GUIDELINE II-N. COMMUNITY PORTALS AND APPROPRIATE PLACES FOR PREHEARING DETENTION SHOULD BE CLEARLY IDENTIFIED, AND DUTIES AND AUTHORITIES SHOULD BE DELINEATED. THIS INFORMATION SHOULD BE DISSEMINATED TO LAW ENFORCEMENT OFFICIALS, COURT PERSONNEL, GATEKEEPERS, AND OTHER OFFICIALS IN THE MENTAL HEALTH-JUDICIAL SYSTEM.

Comment

This guideline is consistent with previous ones in encouraging simple and workable procedures in the initial stages of involuntary commitment. Practical considerations for law enforcement officials and gatekeepers should be a major concern. Peace officers should know where to transport respondents, and gatekeepers should know where to refer respondents without delay.

GUIDELINE II-O. THE COURT SHOULD ENSURE THAT PROMPT NOTICE OF A PERSON'S DETENTION PURSUANT TO INVOLUNTARY COMMITMENT IS GIVEN TO APPROPRIATE INDIVIDUALS AND AGENCIES.

Comment

Minimizing the disruption of a respondent's life, and providing legal protections and other assistance to a respondent, necessitate notice to individuals able to help the respondent. Only those persons legitimately needing to know of a person's involuntary detention should be informed. If particular individuals or agencies are likely to need notice sooner than others, care should be taken to notify them first. The court should see that notification procedures comport with statutory requirements, and do not require complex or onerous procedures with little benefit to the respondent. Practical considerations from the respondent's perspective and fiscal considerations of the agency making the notification, should be of major concern.

CHAPTER THREE

REVIEW OF ALLEGATIONS AND SCREENING OF CASES BEFORE DETENTION

Review of allegations, screening, and diversion from involuntary commitment, before a respondent is taken into custody and involuntarily detained in a hospital, is preferable to review of allegations and screening after admission to a hospital. Although progressive state statutes implicitly acknowledge the desirability of screening and diversion from involuntary commitment prior to detention, only a few prescribe the mechanisms by which such actions should be taken. This chapter considers the submission of evidence, in the form of written and oral reports, intended to justify commitment proceedings. Also considered are the review and investigation of this evidence (including direct evaluation of the allegedly mentally disturbed person) for the purpose of screening cases inappropriate for involuntary civil commitment.

Only the screening mechanisms and procedures occurring before involuntary hospitalization are discussed in this chapter. The screening and diversion of cases resulting from mental health examinations and other procedures after a person has been involuntarily hospitalized will be discussed in Chapters Four and Five.

THE LAW

Petitions, Applications, and Other Documents Supporting Commitment

The petitions, applications, and other documents (written and oral) submitted pursuant to the involuntary civil commitment of an individual, are intended to serve several related purposes. First, they justify actions which directly or indirectly involve the respondent. These actions include, for example, the interviewing of friends, relatives, mental health personnel, and others who may have come in contact with the respondent, and the questioning and examination of the respondent him or herself. In emergency cases, the report justifying emergency action, custody-taking, and involuntary detention, is usually filed after these actions occur. Second, they are the basis for testing the validity of allegations concerning the respondent, and for investigating the appropriateness of proceeding toward involuntary civil commitment. The third purpose served by petitions, applications, and other evidence is to trace a history of circumstances and facts germane to the care and treatment of the respondent. State statutes reflect these basic purposes.

Some states allow initiation of commitment proceedings upon a verbal report of circumstances, made to a peace officer or mental health professional, particularly in emergency circumstances (e.g., Iowa, New York). Statutes may require, however, that a written record or application be filed within a specified time after the person is admitted to a hospital. Most states require that a petition, affidavit, or application be filed with the court to begin commitment proceedings. The

affidavit, petition, or application serves, in effect, as a formal allegation by one person (the affiant, petitioner, or applicant) that another person (the respondent) requires compulsory hospitalization. From a strict legal point of view, the petition, affidavit, or application constitutes, the formal allegation to establish probable cause to believe that a respondent should be subject to compulsory hospitalization. In Ohio, for example, any person or persons having "reliable information or actual knowledge" may file an affidavit with a court. For the court to involuntarily hospitalize a person, the affiant must file the affidavit with the court. A "doctor's letter" (a written statement by a psychiatrist, psychologist, or physician, or a "pre-screener" from a community mental health center) must accompany the affidavits certifying that the doctor has examined the person and believes him or her to be mentally ill and a proper subject for judicial hospitalization.

The requirements for written certifications and reports pursuant to emergency commitment are more relaxed than those required for judicial commitment. Applications for emergency hospitalization executed by peace officers or mental health professionals typically need not be accompanied by certifications that the person has been examined by a mental health professional. Also, applications for emergency hospitalization need only be submitted to the mental health facility to which emergency admission is sought; court review and approval is not required. In Columbus, Ohio, the person transporting the allegedly mentally ill person to the hospital is required to present a written statement to the hospital indicating the circumstances and reason for the emergency action. A preprinted form is used for this purpose. This form is similar to a formal affidavit filed with the court pursuant to judicial commitment in that it requires the transporting person to indicate (by checking the appropriate box on the form) the applicable compulsory hospitalization criteria, and to make a written statement supporting his or her belief that emergency hospitalization is necessary.

In some states, the following information may be required to be affirmed under oath, in the petition, affidavit, or application for involuntary civil commitment:

- Statement of alleged facts that are sufficient to indicate "probable cause to believe that the person is a mentally ill person subject to hospitalization by court order" (Ohio)
- Statement of allegations that one or more of the statutory criteria for involuntary commitment have been met (Ohio, Illinois, Indiana)
- Description of overt acts or threats (Illinois)
- Personal information about the respondent, family history, and history of mental illness (Ohio, Illinois)
- Financial statement for liability for support which is conveyed to the hospital or mental health facility for the purposes of recovery of mental health care and treatment costs (Ohio)

Declaration of personal observations (Arizona)
Declaration of the impossibility of obtaining a temporary order of commitment (New Jersey)
Statement regarding the availability of treatment (Idaho)
Declaration of respondent's current status as a voluntary patient and whether or not he or she has requested release (Idaho)

Some states require the affidavit, petition, or application to be accompanied or supported by one or more certificates completed by mental health professionals. The certificates are statements filed by qualified examiners (who may be social workers, nurses, physicians, psychiatrists, or psychologists, as recognized by statute) in support of the petitioner's, affiant's, or applicant's contentions. Illinois, for example, requires that two certificates be filed independently; at least one of these must be completed by a psychiatrist. For an emergency commitment, the second examiner must also be a psychiatrist.

State statutes may allow initiation of a commitment without the required medical certificates if such certification has been impossible to obtain, especially in emergency situations. In Ohio, for example, a court may take an affidavit without a "doctor's letter" if the affiant claims that the respondent "has refused to submit to an examination by a psychiatrist, or by a licensed physician", though the court in at least one Ohio city (Columbus) seldom does so in practice. Statutes vary in the number of medical certificates that must be filed, and the precise times for filing. Most states require one examination and certificate; some require two (e.g., Illinois) or more (e.g., Wisconsin). Certificates may be required to include such items as:

Declaration by the examiner that a mental health examination of the respondent was held within a specified time (Illinois)
Statement of the examiner's clinical observations and conclusions (Illinois)
Statement by the examiner that the respondent was advised of his or her right to remain silent (Illinois)
Declaration that the respondent meets specified criteria for commitment (Oklahoma)
Statement of facts and circumstances that are the bases for the statements made in the certification (New York)
Statement regarding the relationship of the examiner to the petitioner, affiant, or applicant (New Jersey)
Information regarding the examiner's licensure (New Jersey)
Information about the respondent's history of previous mental illness (Ohio)
Declaration that an examiner has personally examined the respondent (Idaho)
Statement of allegation of the respondent's

incompetency to make treatment decisions (Idaho)
Declaration that the respondent refused mental health examination (Idaho)

At least one state (California) requires a comprehensive report to initiate proceedings to establish a guardianship for treatment purposes. Such a report must contain information that is biographical, medical, financial, vocational, and social, and that describes all available treatment alternatives.

Screening Mechanisms

A statute may require or authorize optional procedures to investigate and screen allegations and supporting documents, or to examine the respondent. Typically, if investigators or screeners determine that the required information provided is incomplete, inaccurate, or inadequate, or that the respondent does not meet the commitment criteria, the proceedings will be halted and the respondent will be released (if he or she was detained at the time of the examination).

Some state statutes allow, but do not require, the court to order investigation and screening of a case after the filing of a affidavit, petition, or application, but before a person is taken into custody. In Ohio, for example, at the court's direction, a social worker or other court-appointed investigator may make the investigation. Such investigations cover the allegations in the affidavit and any other information regarding whether the person named in the affidavit is mentally disturbed and should be subject to involuntary hospitalization. In Columbus, Ohio, by the authority of the Probate Court, community mental health centers perform extensive mental health screening even before an affidavit is actually filed with the Probate Court. Also, prior to issuing a temporary order of detention, a referee (an attorney hired by the court) reviews an affidavit, once it is filed, and determines ex parte whether probable cause exists to believe that the person should be subject to involuntary hospitalization.

In California, any person may apply to a designated county agency for a petition alleging that he or she knows of a person who should be subject to involuntary hospitalization. The petition requests a professional mental health evaluation of the allegedly mentally disturbed individual before he or she is taken into custody pursuant to involuntary hospitalization. Before filing the petition with the court, a county agency must screen the request to determine whether probable cause to believe the allegations exists 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 that conducted the screening should file the petition and the screening report with the court. If it appears to the court that the person identified in the petition meets the commitment criteria, the court should issue an order commanding the person to submit to mental health evaluation. In Los Angeles County, where the Institute conducted an extensive study of the commitment process, this path to court-ordered

evaluation and treatment in non-emergency cases is almost never traveled (see Los Angeles, p. II-4).

Several other states authorize the investigation and review of cases by mental health professionals before custody-taking and detention (e.g., Arizona, Washington). Other states (e.g., North Carolina, Iowa) require that court personnel review petitions, affidavits, and applications, for completeness, accuracy, and adequacy to proceed with commitment proceedings.

GUIDELINES

The guidelines in this chapter propose that petitions, affidavits, applications, and other documents submitted in support of commitment, be rigorously executed, investigated, and reviewed, to avoid the unnecessary detention and forced hospitalization of persons for whom alternatives are more appropriate. The factual information contained in petitions, affidavits, and applications should be sufficient to facilitate investigation, review, and testing of the appropriateness of compulsory hospitalization. The guidelines also suggest the development of mechanisms to screen and divert a maximum number of cases from involuntary commitment.

Petitions, Applications, and Other Documents

GUIDELINE II-P. (1) REGARDLESS OF THE COMMITMENT ROUTE, AUTHORIZATION TO INITIATE COMMITMENT PROCEEDINGS SHOULD ALWAYS BE BASED ON A WRITTEN APPLICATION COMPLETED AND FILED WITH DESIGNATED COMMUNITY PORTALS BEFORE A PERSON IS TAKEN INTO CUSTODY AND DETAINED PURSUANT TO INVOLUNTARY CIVIL COMMITMENT.

(2) BEFORE A WRITTEN APPLICATION CAN BE FILED, AND BEFORE SCREENING OF THE CASE AS DESCRIBED IN GUIDELINE II-S, IF A GATEKEEPER DETERMINES THAT IMMEDIATE DETENTION AND HOSPITALIZATION IS NECESSARY TO PREVENT SERIOUS BODILY HARM TO THE RESPONDENT OR OTHERS, SUCH AN APPLICATION MAY BE FILED WITH A DESIGNATED PORTAL WITHIN 24 HOURS OF THE RESPONDENT'S ADMISSION TO A MENTAL HEALTH FACILITY. IN SUCH EMERGENCY CIRCUMSTANCES, THE ADMITTING FACILITY SHOULD TRANSMIT THE APPLICATION, AND THE COMMUNITY PORTAL SHOULD BE RESPONSIBLE FOR SCREENING.

GUIDELINE II-Q. A WRITTEN APPLICATION FOR INVOLUNTARY CIVIL COMMITMENT MUST ALLEGE THAT A RESPONDENT SHOULD BE SUBJECT TO COMPULSORY HOSPITALIZATION. IT SHOULD SPECIFY THE FACTUAL INFORMATION ON WHICH ALLEGATIONS ARE BASED INCLUDING: (a) A DESCRIPTION OF OVERT ACTS, SPECIFIC THREATS, OR SPECIFIC CIRCUMSTANCES, INDICATING THAT THE RESPONDENT IS A LIKELY CANDIDATE FOR INVOLUNTARY COMMITMENT; (b) PERSONAL INFORMATION

ABOUT THE RESPONDENT INCLUDING HIS OR HER PRESENT LOCATION, PERMANENT RESIDENCE, AGE, PHYSICAL DESCRIPTION, EDUCATION, FINANCIAL CONDITION, FAMILY HISTORY, AND HISTORY OF MENTAL AND PHYSICAL ILLNESSES AND PREVIOUS HOSPITALIZATIONS; (c) NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF FAMILY MEMBERS AND ACQUAINTANCES OF THE RESPONDENT, AND ALL PERSONS KNOWN TO THE APPLICANT WHO HAVE KNOWLEDGE OF SUCH FACTUAL INFORMATION THROUGH PERSONAL OBSERVATION.

GUIDELINE II-R. APPLICATIONS TO GATEKEEPERS SHOULD BE READILY AVAILABLE AT DESIGNATED PORTALS AND MAY BE EXECUTED BY ANY ADULT PERSON WITH THE ASSISTANCE OF GATEKEEPERS. A SINGLE PREPRINTED FORM SHOULD BE USED FOR ALL COMMITMENT APPLICATIONS, REGARDLESS OF THE ROUTE TAKEN.

Comment

Guidelines II-P through II-R are consistent with previous guidelines in providing a single, relatively simple mechanism whereby applications for involuntary civil commitment, regardless of commitment route, must be submitted to community portals for investigation and review. The applications should contain sufficient information to enable gatekeepers to make sound decisions concerning immediate diversion of the case from compulsory hospitalization, the initiation of investigation of the application, and the screening and evaluation of the respondent.

The court, whenever possible, should ensure that specific overt acts or threats be recorded on applications in support of the allegations that a person is dangerous to self or others, or is unable to care for his or her basic physical needs. Without an overt act or threat requirement, a respondent may be taken into custody and involuntarily detained on the basis of conclusionary statements and unsubstantiated opinions presented by an applicant. Even if a respondent is not taken into custody and detained on the basis of unsubstantiated allegations, decisionmaking by gatekeepers will be delayed until descriptions of overt acts, specific threats, or special circumstances are discovered by investigators and screeners. On the other hand, an absolute requirement for an overt act or threat may prevent the commitment and treatment of a person whom mental health professionals believe has the potential to cause great harm. Thus, the above guidelines encourage the court to seek reports of specific behaviors or threats as evidence whenever possible, but to accept applications and proceed with investigation, review of applications, and screening of cases whenever deemed prudent by gatekeepers.

Screening and Diversion of Cases

GUIDELINE II-S. WHEN A COMMUNITY PORTAL RECEIVES A REQUEST FOR AN APPLICATION FOR INVOLUNTARY COMMITMENT, A GATEKEEPER SHALL: (a) IMMEDIATELY DETERMINE WHETHER TO PURSUE COMMITMENT PROCEEDINGS, OR TO ADVISE THE

APPLICANT TO SEEK ALTERNATIVES TO COMPULSORY HOSPITALIZATION; (b) IF SUCH ALTERNATIVES ARE NOT PURSUED BY THE APPLICANT, ASSIST THE APPLICANT IN COMPLETING THE APPLICATION FOR INVOLUNTARY COMMITMENT; AND, (c) PREPARE FOR A REVIEW AND INVESTIGATION, OF THE APPLICATION, AND SCREENING OF THE CASE.

GUIDELINE II-T. (1) WHEN A COMMUNITY PORTAL RECEIVES AN APPLICATION, AND A GATEKEEPER DETERMINES THAT INVOLUNTARY COMMITMENT PROCEEDINGS SHOULD BE INITIATED PURSUANT TO GUIDELINE II-S, PARAGRAPH (a), THE GATEKEEPER SHALL CAUSE AN INVESTIGATION AND REVIEW OF THE APPLICATION, AND POSSIBLE SCREENING AND DIVERSION OF THE RESPONDENT FROM COMPULSORY HOSPITALIZATION, TO BE COMPLETED BY THE END OF THE SECOND DAY AFTER RECEIPT OF THE APPLICATION.

(2) INVESTIGATION AND REVIEW OF THE APPLICATION SHALL INCLUDE THE FOLLOWING: (a) REVIEW AND ASSESSMENT OF THE RELIABILITY AND CREDIBILITY OF ALL FACTUAL INFORMATION CONTAINED IN THE WRITTEN APPLICATION AS PRESCRIBED IN GUIDELINE II-Q, PARAGRAPHS (a) THROUGH (c); AND, (b) INTERVIEWS OF THE APPLICANT AND AVAILABLE WITNESSES WHO HAVE KNOWLEDGE OF THE RESPONDENT THROUGH PERSONAL INFORMATION.

(3) SCREENING SHALL INCLUDE A PERSONAL INTERVIEW WITH THE RESPONDENT WHEREUPON A DETERMINATION IS MADE TO PURSUE INVOLUNTARY CIVIL COMMITMENT OR TO DIVERT THE RESPONDENT TO LESS RESTRICTIVE TREATMENT AND CARE. THE INTERVIEW SHALL BE CONDUCTED AT A COMMUNITY PORTAL AT A SPECIFIC TIME AND DATE OR, IF THE RESPONDENT IS UNWILLING OR UNABLE TO COME TO THE PORTAL, AT THE RESIDENCE OR OTHER LOCATION OF THE RESPONDENT OR, IF A PERSONAL FACE-TO-FACE INTERVIEW CANNOT BE ARRANGED WITHIN THE PRESCRIBED TIME LIMITS, THE INTERVIEW MAY BE CONDUCTED BY TELEPHONE. THE INTERVIEW SHALL INCLUDE: (a) GIVING THE RESPONDENT A COPY OF THE COMPLETED APPLICATION AND AN ORAL EXPLANATION OF THE NATURE, PURPOSE, AND POSSIBLE CONSEQUENCES OF THE INTERVIEW; (b) WRITTEN NOTICE AND ORAL EXPLANATION OF ALL RIGHTS PRESCRIBED BY LAW, AND AN OFFER OF ASSISTANCE TO THE RESPONDENT TO REALIZE THOSE RIGHTS; AND, (c) MENTAL HEALTH SERVICES SUCH AS CRISIS INTERVENTION, COUNSELING, MENTAL HEALTH THERAPY, AND OTHER PSYCHIATRIC, WELFARE, PSYCHOLOGICAL, AND LEGAL SERVICES AIMED AT AVOIDING UNNECESSARY AND INAPPROPRIATE COMPULSORY HOSPITALIZATION AND PROVIDING CARE AND TREATMENT IN THE LEAST RESTRICTIVE SETTING.

GUIDELINE II-U. (1) AT THE COMPLETION OF THE INVESTIGATION, REVIEW, AND SCREENING, THE GATEKEEPER SHALL DETERMINE WHETHER TO PURSUE COMMITMENT

PROCEEDINGS, TO DIVERT THE CASE TO SOME ALTERNATIVE TREATMENT OR CARE, OR TO TERMINATE ANY FURTHER ACTIONS IN THE CASE.

(2) IF THE GATEKEEPER DETERMINES THAT THE RESPONDENT MEETS THE COMMITMENT CRITERIA AND THAT THE RESPONDENT CANNOT BE SERVED IN A SETTING LESS RESTRICTIVE THAN THAT PROVIDED BY COMPULSORY HOSPITALIZATION WITHOUT GIVING RISE TO IMMEDIATE AND SUBSTANTIAL RISKS TO THE RESPONDENT OR OTHERS, THE GATEKEEPER SHOULD CAUSE THE RESPONDENT TO BE TAKEN TO A MENTAL HEALTH FACILITY PURSUANT TO INVOLUNTARY COMMITMENT.

GUIDELINE II-V. (1) THE GATEKEEPER SHALL CAUSE A REPORT OF THE REVIEW, INVESTIGATION, AND SCREENING PURSUANT TO GUIDELINE II-T, TO BE SUBMITTED TO THE COURT WITH THE APPLICATION FOR INVOLUNTARY CIVIL COMMITMENT NO LATER THAN THREE DAYS AFTER RECEIPT OF THE APPLICATION.

(2) THE FORM AND CONTENT OF THE SCREENING REPORT SHALL BE CONSISTENT WITH THE OVERVIEW AND REGULATION OF THE COMMITMENT PROCESS BY THE COURTS PRESCRIBED IN GUIDELINES II-A THROUGH II-D.

Comment

Guidelines II-S through II-V encourage the accomplishment of reviewing, investigating, and screening, of mental health cases before a respondent is taken into custody pursuant to involuntary civil commitment. In all cases, gatekeepers must cause a review and investigation of the application for involuntary civil commitment, and must accomplish a screening, to avoid unnecessary detention and compulsory hospitalization when (1) there are inadequate grounds to believe that the respondent presents a likelihood of serious harm to self or others as a result of mental disorder, and (2) when there are less restrictive alternatives for care and treatment available to the respondent. The review, investigation, and screening should be completed prior to custody-taking and detention, unless a gatekeeper or a peace officer, upon consultation with a gatekeeper, determines that immediate detention is necessary to prevent serious harm to the respondent or others. In such emergency cases, at least telephone contact and consultation between a gatekeeper and a peace officer should establish the necessity for immediate detention. Even in such emergency cases, however, the filing of an application for involuntary commitment, and investigation, review, and screening, should occur after detention as prescribed in Guidelines II-P through II-V.

The screening guidelines in this section propose that all requests and actions pursuant to involuntary civil commitment be funneled through community portals. The development of mechanisms for screening, investigation, and review of cases before a formal judicial hearing takes place, must be achieved by a cooperative effort involving mental health

practitioners, court personnel, and to a lesser extent, law enforcement officials. Review and investigation of cases, and screening and diversion of respondents from compulsory hospitalization, serve the interests of the respondent, the applicant or petitioner, the court, and the taxpayer. The respondent's interests are met by the avoidance of unnecessary detention and involuntary hospitalization, as well as his or her interest in access to less restrictive mental health care and treatment. The applicant or petitioner's interests are served by providing immediate support and assistance for a person whom he or she believes is incapable of caring for him or herself, and by providing an education resource during a time of crisis. The courts and the community are served by a more efficient and economical allocation of resources.

Investigation and review of requests for involuntary civil commitment, and prehearing screening and evaluation of cases before a respondent is taken into custody, appear to be very advantageous in those few jurisdictions now using these practices.

> The Columbus [Ohio] procedures for screening, investigating, and reviewing of mental health cases before the respondent is taken into custody are exemplary. There is obviously less curtailment of liberty for those individuals successfully diverted from judicial hospitalization as a result of the initial contact with the Probate Court, the community mental health centers pre-screening, and finally, the ex parte review of the allegations in the affidavit by a referee. The screening procedure, once successful in diverting mentally ill individuals from judicial hospitalization, also embody the best interest of law and mental health practice by providing the opportunity for treatment in a least restrictive environment that is less disruptive of family, social, and economic ties and activities of respondent.
>
> Although contemplated in most progressive involuntary civil commitment statutes throughout the country, the Ohio law not excepted, it is a rare occurance, indeed, when a respondent remains at liberty pending a judicial hearing but after an affidavit has been filed. Society simply does not seem willing to bear whatever burden may be involved in maintaining contact with the respondent outside of a hospital during the prehearing period, except in very rare domestic cases. The three screening mechanisms employed in Columbus provide prompt, reliable, and effective decisionmaking about whether respondents should be taken into custody in the first place... .

> The screening mechanisms also appeared extremely advantageous for the people of Columbus because they seem cost-effective. In the absence of such screening mechanisms (assuming even very conservative estimates of the number of people diverted from judicial hospitalization) it is not inconceivable that judicial costs would soar. (Columbus, p. 37).

CHAPTER FOUR

PREHEARING MENTAL HEALTH EXAMINATION AND TREATMENT

The preceding three chapters considered prehearing matters pertaining to the process of involuntary civil commitment before a respondent is detained involuntarily in a mental health facility. This chapter begins the consideration of important events and procedures involving the mental health examination and the delicate matter of the treatment and care of a respondent before judicial hearing but after he or she has been taken into a hospital against his or her will.

THE LAW

Prehearing Examinations

Statutory requirements for mental health examinations conducted once a respondent has been taken into custody reflect several basic purposes that may or may not be expressly articulated in statutes. A basic purpose of mental health examinations is to test the allegations in petitions, affidavits, and applications for compulsory hospitalization. Another purpose is to determine, from the perspective of mental health facility personnel, whether a respondent should be involuntarily hospitalized or whether the respondent's needs can be best met by treatment and care other than compulsory hospitalization. Yet a third, related purpose of mental health examinations prior to hearings is to provide evidence for well-informed judicial determinations concerning prolonged compulsory hospitalization.

Most states require at least two prehearing mental health examinations, the first to be conducted shortly after or at the time of admission and the other a few days thereafter. In Illinois, for example, two examinations are required to detain a respondent in a mental health facility and to bring the commitment issue to a formal judicial hearing. Illinois statute requires that the first examination take place at or before the time that a petition is prepared and a respondent is taken into custody. In any event, an examination by a psychiatrist (whether it is the first or second examination) must be performed within 24 hours of the time that a respondent is admitted to a mental health facility. In practice, respondents almost always receive both examinations within a 24-hour period following their admission to a mental health facility; no one is held for a period of time greater than 24 hours without at least one examination. Illinois also allows a respondent to request an independent examination. In practice, however, independent examinations rarely occur.

In Columbus, Ohio a respondent is likely to receive at least four mental health examinations before he or she appears at a judicial hearing (see Columbus, p. 46). A social worker at a community mental health center performs the first prior to custody-taking. Hospital staff perform the second within 24 hours after the respondent's arrival. The hospital must admit emergency cases for "observation, diagnosis, care,

and treatment," but if after an examination of the person, the head of the hospital believes that hospitalization is unwarranted, he or she must release the person. A psychiatrist appointed by the court conducts the third mental health examination to determine the mental condition of the respondent, and the need for custody, care, or treatment in a mental hospital. An independent expert, usually a psychiatrist, conducts the last examination of the respondent. Although statute provides the respondent the right to select a psychiatrist, a physician, or a licensed-clinical psychologist, to evaluate his or her mental condition, because most respondents in Columbus are indigent and because expert evaluation is provided at public expense, independent experts are appointed by the court.

In New York, persons presented for involuntary hospitalizations pursuant to emergency admissions are examined prior to admission, and again within 48 hours. The second examination is to confirm the first examiner's findings. The examiner conducting the second examination must be a member of the psychiatric staff of the hospital.

Statutes use three main time frames for specifying the timing of mental health examinations: (1) a restriction on the time before a respondent must be examined after the occurrence of some important event in the commitment proceedings (e.g., the issuance of a court order or, more commonly, hospital admission); (2) a restriction on the timing for the appointment of an examiner (with the timing of the mental health examination, per se, not necessarily specified); or (3) a restriction on the time between mental health examination and judicial hearing. The first time frame is by far the most common.

There is little variation among states concerning the types of individuals who may perform prehearing examinations. Most states require mental health professionals (physicians, psychiatrists, clinical psychologists, and social workers) licensed or certified within the state. Some states (e.g., New Jersey) require that mental health examiners be unrelated to the respondent and unaffiliated with the institution to which application for commitment is made. Other states specify combinations of various mental health professionals that may be involved in the examination procedure. For example, Minnesota requires that examinations be conducted by two physicians, one of which is a psychiatrist; Iowa requires two physicians, both psychiatrists if possible; Illinois requires a psychiatrist and at least one other qualified examiner.

The statutes in a few states (e.g., Arizona, Illinois, New York, Ohio) provide respondents with the right to request an independent examination. Though the statutes in New York and Ohio provide such rights, independent examinations rarely occur in practice in New York City and Chicago. Neither the Illinois statute nor practice in Chicago has established a mechanism for funding independent examinations (see Chicago, p. 45). Requesting an independent examination usually means that a hearing will be delayed at least one week, which has been a disincentive for respondents to request these examinations. Independent examiners in Chicago are appointed by the judges (rather than being

freely chosen by respondents) from the staff of the Department of Mental Health and Developmental Disabilities. Chicago attorneys feel that these examiners are not "independent" because they are affiliated with the regular hospital examiners, have access to and use the other examiners' notes, and probably discuss the case with the other examiners. In New York City, the request for an independent examination is made to the judge, who has discretion to appoint a physician to examine the respondent. The examiner, who cannot be on the staff of the hospital where the patient is committed, is selected from a pool of examiners maintained by the court. As in Chicago, independent examinations are seldom requested, reportedly because these examinations may delay the hearing for one to two weeks.

The required elements of mental health examinations vary considerably from state to state. Some statutes fully describe, albeit in general terms, what an examination must include. For example, California requires a multi-disciplinary professional analysis of the respondent's medical, psychological, educational, social, financial, and legal conditions as they may appear to constitute a problem. Pursuant to conservatorships in California, the examiner's report to the court must be comprehensive: it must contain all relevant aspects of the respondent's medical, psychological, financial, family, vocational, and social conditions, and all available information concerning the respondent's real and personal property. Texas requires the biographical data, as well as diagnosis, opinion concerning the need for treatment and the likelihood of injury to self or others, and a description of the length and type of treatment recommended by the examiner. Other statutes do not specify the elements of an adequate examination, but may prescribe a written form or certificate to be submitted to the court, from which the required elements may be deduced. Although North Carolina does not specify the elements of a mental health examination, the physician's findings and the supporting facts must be in writing and must be transmitted to the clerk of court by "reliable and expedious means."

A few states require mental health examinations to be accompanied by a notification of rights and a fair explanation of the purpose, nature, and consequences, of the examination and of the commitment proceedings as a whole. Wisconsin and Illinois require that a respondent be notified of the right to remain silent during the mental health examination. New York requires that immediately upon a respondent's admission to a hospital, the hospital director must inform the respondent in writing of his or her status, of his or her rights, and of the availability of the Mental Health Information Service for assistance.

Prehearing Care and Treatment

Strong conflicting interests are at stake in mental health treatment before full judicial review. On the one hand, when the respondent is first admitted to a mental health facility, a judicial review usually has not yet determined that the respondent meets the involuntary civil commitment criteria. The respondent may, in fact, have been wrongly detained. On the other hand, the respondent's deteriorating

mental condition and aberrant behavior may seriously threaten not only his or her own safety, but that of others in the hospital. To make matters more difficult, economy, efficiency, and convenience, must also be acknowledged and considered in attempting to balance conflicting values.

Although state statutes and courts have dealt extensively with treatment after judicial hearings, only a few statutes specifically address the issues of prehearing treatment. For example, except for especially intrusive treatments (e.g., psycho-surgery and convulsive treatments), California's Lanterman-Petris-Short Act fails to 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. In practice, prehearing treatment engenders relatively little controversy in Los Angeles County (see Los Angeles, p. II-5). The North Carolina statute provides that, pending the court hearing, a qualified physician attending the respondent is authorized to administer to the respondent "reasonable and appropriate medication and treatment that is consistent with accepted medical standards" (see North Carolina, p. 36).

Generally, state statutes allow mental health and medical treatment of respondents before judicial hearing, but with qualifications (e.g., in respondent's "best interest"), with restrictions (e.g., time limits on treatments), with exceptions (e.g., convulsive therapy), or with procedural safeguards (e.g., subject to consent, protection of civil rights). Treatment matters unique to the period of compulsory hospitalization before judicial hearing are not addressed in many state statutes.

GUIDELINES

Typically, a respondent is screened and evaluated, both formally and informally, several times during commitment proceedings. The first screening, as discussed in the previous chapter, usually occurs when a designated gatekeeper assesses whether sufficient grounds exist to trigger involuntary detention, prehearing evaluation, and treatment in a mental health hospital. The next test to the appropriateness of involuntary hospitalization occurs at the admission to a mental health facility, or shortly thereafter. Because many respondents are diverted from involuntary hospitalization to a less restrictive form of care, or are released after admission but before a judicial review of commitment, investigation and screening in the community, and examination in the facility, are as crucial to the period of prehearing commitment as the adversary hearing is to prolonged compulsory hospitalization.

In general, the courts are encouraged to achieve a greater coordination between the screening in the community (see Guidelines II-P through II-V in the previous chapter) and the prehearing examinations, treatment, and care, provided in mental health facilities. Further, the courts should strive for better coordination between their own efforts to provide a base of factual information needed for judicial review and the mental health examinations of respondents performed in mental health

facilities. Cooperative strategies among community services, inpatient mental health facilities, and courts, may serve the interests in economy and efficiency by reducing the waste of resources caused by procedures which are otherwise often meaningless and redundant. They may further serve the respondent's interests in avoiding needless confinement and in getting adequate care and treatment if needed. The guidelines in this chapter are consistent with these general themes.

GUIDELINE II-W. PREHEARING MENTAL HEALTH EXAMINATIONS OF RESPONDENTS PERFORMED IN INPATIENT MENTAL HEALTH FACILITIES SHOULD BE FUNCTIONALLY AND EXPEDITIOUSLY LINKED WITH BOTH PRIOR SCREENINGS AND INVESTIGATIONS IN THE COMMUNITY, AND SUBSEQUENT JUDICIAL REVIEWS BEFORE AND DURING COURT HEARINGS. THE SERIES OF SCREENINGS AND EVALUATIONS PURSUANT TO INVOLUNTARY CIVIL COMMITMENT SHOULD BE SIMPLIFIED AND STREAMLINED TO PROVIDE A SUCCESSION OF EFFECTIVE, EFFICIENT CHECKS ON THE APPROPRIATENESS OF THE COMMITMENT PROCEEDINGS AND TO PROVIDE A CUMULATIVE BASE OF FACTS AND EXPERT OPINIONS. JUDGES, COURT ADMINISTRATORS AND MANAGERS, SHOULD BE INSTRUMENTAL IN EFFECTING THE COOPERATION AND COORDINATION AMONG THE VARIOUS UNITS OF THE MENTAL HEALTH-JUDICIAL SYSTEM TO ACHIEVE THESE ENDS.

GUIDELINE II-X. (1) MENTAL HEALTH EXAMINATIONS SHOULD INCLUDE, AT A MINIMUM: (a) A FULL STANDARD MENTAL STATUS EXAMINATION; (b) AN ASSESSMENT OF WHETHER THE RESPONDENT MEETS THE STATUTORY CRITERIA FOR COMPULSORY HOSPITALIZATION; AND, (c) APPROPRIATE DIAGNOSES, PROGNOSES, AND DETERMINATIONS OF COURSES OF TREATMENT AND CARE IN THE LEAST RESTRICTIVE SETTINGS.

(2) MENTAL HEALTH EXAMINATION REPORTS PROVIDED TO THE COURTS SHOULD STATE THE RESULTS OF THE EXAMINATION AS DESCRIBED IN PARAGRAPH (1), THE EXAMINER'S OPINION WHETHER THE RESPONDENT MEETS THE STATUTORY CRITERIA FOR COMMITMENT, AS WELL AS STATEMENTS ALLOWING COURT PERSONNEL TO ASCERTAIN THE FACTUAL BASES OF THE OPINION.

(3) EXAMINERS WHO PREPARE WRITTEN REPORTS SHOULD BE REQUIRED TO INCLUDE IN THOSE REPORTS STATEMENTS INDICATING WHAT PAST PSYCHIATRIC RECORDS AND OTHER EXAMINERS' OPINIONS THEY CONSULTED BEFORE EXAMINING THE RESPONDENT OR PREPARING THEIR WRITTEN REPORTS. EXAMINERS SHOULD BE ENCOURAGED TO INDICATE, WHENEVER POSSIBLE, WHICH OF THEIR CONCLUSIONS DEPEND SUBSTANTIALLY ON THEIR OWN OBSERVATIONS AND WHICH PRIMARILY ECHO OR REINFORCE PRIOR CONCLUSIONS.

(4) A STANDARD PREPRINTED FORM FOR REPORTING RESULTS OF EXAMINATIONS SHOULD BE DEVELOPED AND USED TO EXPEDITE COMMUNCATION.

GUIDELINE II-Y. (1) THE COURT SHOULD MAKE GREATER USE, AND ENCOURAGE ATTORNEYS TO MAKE GREATER USE, OF THE EXAMINATIONS PERFORMED PURSUANT TO INVOLUNTARY CIVIL COMMITMENT.

(2) EXAMINERS SHOULD BE REQUIRED TO COMPLETE THEIR EXAMINATIONS AND TO SUBMIT WRITTEN REPORTS SUFFICIENTLY IN ADVANCE OF JUDICIAL REVIEWS TO ALLOW ADEQUATE TIME FOR CONSIDERATION OF THE EXAMINATION RESULTS.

(3) ONCE THE VALIDITY AND RELIABILITY OF COMMITMENT DECISIONS ARE ESTABLISHED, IN THE INTEREST OF THE RESPONDENT'S CARE AND TREATMENT, THE COURT SHOULD COORDINATE AND COMPILE THE RESULTS OF THE PREHEARING EXAMINATIONS, AND MAKE THESE RESULTS AVAILABLE TO THE MENTAL HEALTH PERSONNEL RESPONSIBLE FOR THE RESPONDENT'S CARE AND TREATMENT.

Comment

Guidelines II-W through II-Y identify problems and suggest improvements in coordination, management, and utilization of resources already existing in mental health examinations. Generally, information acquired during prehearing mental health examinations is inadequately used. For example, before a respondent in Columbus, Ohio, appears at a probable cause hearing, he or she is likely to receive at least four mental health examinations. If the court required that a two to three page report of each of these examinations be provided to the court and to each party's attorney, insufficient data to test the allegations would seem unlikely. Apparently, however, only one report typically becomes part of the court record. The limited prehearing time that a repondent's attorney typically has for conferences with examiners, often prevents the full exploration of the examinations until oral testimony at judicial hearing. The interests of economy and efficiency require that the court either fully use these examinations by requiring that written reports be filed, or that the court reduce the examinations required in practice. A similar underutilization of mental health examination results has been observed in other jurisdictions (see Los Angles, p. II-7).

In many jurisdictions, screenings and evaluations fail to provide a cumulative base of factual information and expert opinions about a respondent. For example, although the Illinois statute requires that a mental health facility investigate a respondent's social and family situation, and provide the findings to the judge, this information is seldom so provided (see Chicago, p. 56). Judges in Chicago consider this information necessary to make correct decisions about release and treatment. For example, the knowledge that a respondent has a supportive family, or a religious group that can provide the necessary care and supervision, is critical to a judge considering whether the respondent can remain at liberty in the community.

An often voiced concern about the contents of mental health examination reports is their conclusory nature. Mental health diagnoses and prognoses are not without error. Therefore, to understand a respondent's condition, it is important to understand the facts upon which the diagnosis and prognosis are made, and to have the independent points of view of several examiners. Many examination reports suffer from the failure to include factual statements.

A qualified examiner should be able to reach a diagnosis by examining a respondent, and reading an application for involuntary commitment, without consulting other examiners or their notes. If records of previous psychiatric treatment were available to examiners, they would likely produce a strong bias that the respondent is mentally disturbed. Mental health professionals indicate that previous mental health records are necessary for an exact diagnosis of mental illness (see Columbus, p. 58). While such records are frequently useful in making a differential diagnosis, it is doubtful that they are required to determine simply whether a person is mentally ill, which is all that is necessary to satisfy statutory criteria. The problem is not merely legal, however. Because the examination is also used for treatment purposes, the problem is also medical. Treatment staff have a valid and important need for mental health histories, and for other examiners' opinions and records, in planning treatment strategies.

Because mental examinations serve both legal needs and treatment needs, a genuine dilemma is created. From a legal perspective, examinations should be independent and uninfluenced by previous treatment histories and opinions. From a treatment standpoint, this information is critically necessary.

Guideline II-X, paragraph (3), suggests that if an examiner refers to records or confers with other examiners, he or she should report the nature and extent of information that might have influenced his or her conclusions about the respondent's condition. From this information, a judicial review can determine whether enough current and independent evidence exists to justify a respondent's commitment.

Guideline II-X, paragraph (1), provides that mental health examinations should include, at a minimum, information sufficient to show that a careful mental health examination has been conducted and to show the factual basis for the examiner's opinions and conclusions. What constitutes a "standard mental health examination," and the operational definitions of several elements of examinations proposed in Guideline II-X, undoubtedly, will generate differences among psychiatrists, pschologists, and other mental health professionals. This should not detract, however, from the importance of this guideline.

A final consideration concerning the use of mental health examinations is the availability of examination results to inform care and treatment decisions. The independence of the various examinations serves to test the allegations and the arguments for and against compulsory hospitalization. Once the test has been conducted, however, independence serves no further purpose; access to all information for

treatment purposes becomes a primary interest. The initial screening report, with a detailed account of a respondent's behavior in the community, and a full description of his or her mental condition at the custody-taking, would be useful to the treating mental health professionals. Second and third opinions of mental health examiners would be of further value.

> GUIDELINE II-Z. THE COURTS SHOULD URGE EXAMINERS TO CAREFULLY EXPLAIN TO EVERY RESPONDENT THE RIGHTS OF THE RESPONDENT, AND THE PURPOSE, NATURE, AND LIKELY CONSEQUENCES OF EACH EXAMINATION, INCLUDING ITS PLACE IN THE COMMITMENT PROCEEDINGS.

Comment

State statutes do not require examiners to disclose the purpose, nature, and consequences of the examination process in involutary civil commitment proceedings. Only a few states require that a respondent be informed of his or her right to remain silent during examinations. Nonetheless, even if not required by law, on the basis of professional ethics, such explanations should be given to every respondent before examination. Admittedly, few examiners would like to begin interactions with respondents by "reading their rights" to them. Perhaps imagining a scene in which a criminal defendent is read his Miranda warnings by police while leaning against the wall with arms and legs extended, most would feel that this instantly destroys any chance for candid exchange in an atmosphere of trust and support. On the other hand, many examiners who do give frank disclosure and explanation, report that respondents are pleased that an examiner has leveled 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 professionals) are not the negative ones that might be expected. Rather than causing a respondent to be cautious about responses to the examiners, the explanation removes resistances, and respondents speak openly. Whenever permitted by a respondent's mental condition, a full and open disclosure of the purpose, nature, and consequences of the examination in the context of civil commitment process, is dictated by the ethical code of psychiatrists, psychologists, and social workers alike, regardless of requirements of law. In fairness, respondents should know what is happening to them and why. Few examiners, regardless of their attitudes, report that respondents refuse to talk with them as a matter of legal right, although some refuse because they are either too hostile or too sick to communicate (see Columbus, p. 57).

> GUIDELINE II-AA. PREHEARING MENTAL HEALTH TREATMENT AND CARE SHOULD BE ADMINISTERED IN A MANNER CONSISTENT WITH THE APPLICABLE STATE STATUTE, THE PURPOSES FOR WHICH THE RESPONDENT WAS HOSPITALIZED, AND THE ACCEPTED MENTAL HEALTH PRACTICES.

> GUIDELINES II-BB. (1) THE POLICIES OF FACILITIES PROVIDING PREHEARING MENTAL HEALTH TREATMENT SHOULD BE INFORMED BOTH BY LEGAL OPINION REGARDING THE LIABILITY

OF TREATMENT PROVIDERS, AND BY MENTAL HEALTH OPINION ABOUT THE APPROPRIATENESS OF SHORT-TERM TREATMENT.

(2) THE COURTS, AND ATTORNEYS REPRESENTING RESPONDENTS, SHOULD BE FAMILIAR WITH THE TYPES OF PREHEARING TREATMENT GIVEN TO RESPONDENTS, ESPECIALLY WHEN THE TREATMENT INCLUDES MEDICATION LIKELY TO AFFECT THE RESPONDENT'S DEMEANOR AND CAPACITY TO ASSIST COUNSEL DURING JUDICIAL HEARING.

Comment

Absent the likelihood that prehearing treatment, especially medication, will adversely affect a repondent's appearance and behavior during judicial hearings, and his or her ability to assist counsel, no compelling reasons exist for preventing appropriate mental health treatment and care during the prehearing period. If any medication is administered to a respondent during the prehearing period, and if the respondent's treating physician has any reason to believe that the respondent's behavior in court will be affected by the medication, the physician should indicate to the court, the respondent's attorney, and the attorney representing the hospital and state, what medications were administered and what consequences these medications are likely to have on the respondent's behavior during the hearing, and on the respondent's ability to assist counsel. For a more specific discussion and guideline concerning the influences of psychotropic medication at hearing, see Part IV, Chapter Four.

Although few statutes distinguish the treatment and care that should be provided to respondents pending judicial hearing, and to respondents already judicially committed, some mental health professionals are reluctant to treat respondents before ajudication of commitment due to a fear of liability. They may prescribe therapy, but refuse to provide medication. One psychiatrist in Columbus, Ohio, reported that hospital staff sometimes seem preoccupied with liability issues, to the detriment of the best clinical judgments. This preoccupation caused staff to be overly cautious, and caused a disservice to the best interest of respondents pending judicial hearing. Absent a respondent's exercise of his or her right to refuse treatment or care, the reluctance of qualified mental health professionals to provide care and treatment is contrary to the interests to the respondent, the state, and society in general, especially in view of the already strained resources of the mental health service delivery system.

CHAPTER FIVE

DIVERSION AND RELEASE BEFORE JUDICIAL HEARING

Several mechanisms for release and diversion of respondents prior to admission to a mental health facility, already have been considered in this part. Guidelines in Chapter Three encourage the exercise of discretion by gatekeepers to divert cases to more appropriate, less restrictive care and treatment than that provided by compulsory hospitalization. The previous chapter considered the checks on the validity and appropriateness of involuntary hospitalization provided by mental health examinations conducted early during hospitalization but before judicial hearing. If examiners determine that a respondent does not meet statutorily prescribed criteria, the case typically does not proceed to judicial hearing, but is instead "dropped" or diverted to some other form of care or treatment. In the great majority of cases, early release and diversion is of benefit to the respondent and to society as a whole.

This chapter considers the mechanisms whereby prehearing release or diversion of a respondent from compulsory hospitalization can be achieved once he or she has passed the community portals and checkpoints provided by mental health examinations. Once a respondent is hospitalized, release or diversion prior to judicial hearing can be effected in several ways:

(a) automatic release upon an applicant's failure to file the necessary papers within required time limits (e.g., three days for emergency hospitalization);

(b) treating mental health personnel notice improvement in the respondent's condition, and either upon the request of the respondent or on their own initiative, order release;

(c) the respondent successfully requests a change of his or her status to voluntary admission and, thereupon, seeks release; or,

(d) the respondent gains a de facto release by simply walking away or "escaping" from compulsory hospitalization.

THE LAW

Most state statutes permit mental health facilities to discharge respondents before judicial hearing. Broad discretion is given to mental health personnel to make release and diversion decisions. Discharge of a respondent typically occurs if the mental health professional in charge of the respondent's treatment and care believes that compulsory mental health care and treatment no longer are, or never were, necessary.

Dismissal of the commitment proceedings may also occur if procedural statutory requirements for judicial proceedings have not been met. California, Indiana, West Virginia, and Texas, for example, require the immediate release of a respondent upon a failure to fulfill statutory requirements for mental health examination, mental health certification, filing of papers, or issuance of orders within required time limits. Other states (e.g., Indiana, Iowa, North Carolina, Ohio) require release when commitment criteria can no longer be met. In Ohio, for example, if hospital staff fail to find a respondent both mentally ill and dangerous, the head of the hospital must release the respondent (this broad power to discharge a person extends even after judicial hearing). Unless the respondent has been indicted or convicted of a crime, the head of the hospital may discharge a respondent without court authorization or consent (see Columbus, p. 51). Some state statutes (e.g., Iowa, New Mexico, New York) simply require release if no reasonable grounds exist for detaining a person, or if release is appropriate.

In most states, a diversion and subsequent release prior to judicial hearing may be achieved if a respondent requests voluntary status, and if the mental health facility or the court agrees to the conversion from involuntary to voluntary status. The law in some states (e.g., North Carolina, New York) explicitly encourages conversion from involuntary to voluntary status. New York's Mental Hygiene Law, for example, states that "nothing in this article shall be construed to prohibit any facility director from converting, and it shall be his duty to convert, the admission of any involuntary patients suitable and willing to apply therefore to a voluntary status" (Section 9.23). Most statutes give respondents only the right to apply for voluntary admission, not an automatic right to voluntary admission. A facility director may accept or deny the application for voluntary admission. In some states (e.g., Ohio), a facility director must accept a request for voluntary admission, but may detain the respondent for a period of time pending the filing of another petition. In Illinois, even if the facility director accepts a respondent's application for voluntary admission, the statute allows the judge to consider whether such an admission will be in the best interests of the respondent and the public. Thus, a judge may deny a respondent's application for voluntary admission and may hear the case for involuntary commitment. This element of the Illinois statute makes it possible to prevent patients from "abusing" the voluntary application privilege by using it merely as a vehicle for obtaining release within a certain period of time (see Chicago, p. 44). For extensive treatment of the request for voluntary admission in the judicial hearing context, see Part IV, Chapter Two.

Unless a respondent has been indicted or convicted of a crime, most states enpower mental health personnel (e.g., admitting or attending physician, medical director, examiner, or facility director) to release or divert a respondent from compulsory hospitalization. Some states (e.g., Idaho, Iowa, Indiana, and New York) require the court's consent.

Finally, some state statutes require that specified individuals receive notice of a respondent's release or diversion from compulsory hospitalization. In at least two states (North Carolina and Iowa), the

committing court and the mental health facility must have notice of a respondent's release. A minority of states require that the head of the local social services or mental health department be notified of a respondent's release (e.g., New York).

GUIDELINES

With specific procedural safeguards, prehearing release and diversion further the interests of the respondent, those seeking help for the respondent, the state, and the taxpayer. The courts should, therefore, encourage prehearing release and diversion in appropriate cases. The guidelines that follow support the general principle that prehearing release and diversion should be encouraged, but seemingly contrary commentary encourages the courts to ensure that respondents are not released or discharged in inappropriate cases.

> GUIDELINE II-CC. (1) THE COURTS SHOULD REVIEW, MONITOR, INFLUENCE, AND REGULATE, AS MAY BE APPROPRIATE, THE POLICIES AND PROCEDURES FOR THE RELEASE AND DIVERSION OF RESPONDENTS FROM INVOLUNTARY HOSPITALIZATION PRIOR TO JUDICIAL HEARING.
>
> (2) THE COURTS SHOULD BE AWARE OF: (a) THE TOTAL NUMBER OF RESPONDENTS PASSING THROUGH COMMUNITY PORTALS, TAKEN INTO CUSTODY, AND DETAINED PURSUANT TO INVOLUNTARY HOSPITAL ADMISSION; (b) THE PROPORTION OF THOSE RESPONDENTS WHO ARE REFUSED ADMISSION OR ARE DISCHARGED SHORTLY AFTER ADMISSION; (c) THE PROPORTION CONVERTED TO VOLUNTARY ADMISSION IN THE SAME FACILITY; (d) THE PROPORTION TRANSFERRED TO ANOTHER FACILITY AFTER ADMISSION; AND, (e) THE PROPORTION RELEASED PRIOR TO JUDICIAL HEARING.
>
> (3) TO EXPEDITIOUSLY IMPLEMENT PARAGRAPHS (1) AND (2), MENTAL HEALTH FACILITIES AUTHORIZED TO ADMIT INVOLUNTARY PATIENTS SHOULD BE ENCOURAGED TO COMMUNICATE TO THE COURTS, AND THE COURTS SHOULD BECOME FAMILIAR WITH, THE POLICIES AND PROCEDURES FOR RELEASE AND DIVERSION OF RESPONDENTS.

Comment

Guideline II-CC is consistent with the general proposition contained in many of the guidelines in this part that courts pay more attention to and take a greater hand in the prehearing portion of involuntary civil commitment proceedings. Moreover, it is consistent with earlier guidelines in urging coordination and cooperation between the courts and mental health facilites in influencing public policy toward delivery of mental health serivces. Although the guideline favors appropriate release and diversion prior to judicial hearing, it also suggests that the courts help to check inappropriate release or diversion.

The checks and balances applied by courts in reaching release decisions during judicial hearings should also be rigorously conducted during the prehearing process. As the legal and mental health communities become less concerned with improper or protracted periods of compulsory hospitalization, and more concerned with what they consider premature release of persons from inpatient facilities, discharge and release policies and their impact may have to be reviewed. For example:

> Many advocates for the mentally ill in Chicago feel that the major problem in the city is getting help for those who need it--arranging for the mentally ill to get into the hospitals and keeping them there long enough for treatment to become effective. Staff at some of the community mental health centers are frustrated by the public hospitals' tendancies to refuse voluntary admission for people whom the CMHC [community mental health center] staff refer there. Staff from one city clinic estimate that as many as fifty percent of those people whom they feel are appropriate for inpatient treatment and whom they refer to public hospitals are denied admission.
>
> CMHC staff in some instances have begun extraordinary procedures to try to have their referrals by the hospitals. CMHC doctors admit to "coaching" people on what to tell examiners at the hospitals to convince them that they are mentally ill enough for treatment. Sometimes, the doctors at the CMHC's make personal telephone calls to examiners at the hospitals at an attempt to increase the persons likelihood of being accepted into treatment as a backup measure, CMHC psychiatrists are filling out medical certificates to help family members quickly initiate involuntary proceedings in cases where the persons who need help are denied voluntary admission (Chicago, p. 112).

Whether explicitly or implicitly, in deciding whether to release a respondent, the courts generally apply a balancing test, weighing several competing interests: (1) the private, individual interests, especially those of the respondent, that are affected by a particular procedure or official action; (2) the public's interest in the treatment of allegedly helpless and mentally disturbed individuals; (3) the public's interest in protecting itself from those persons thought to be dangerous; and (4) the court's interest in not imposing undue fiscal and administrative burdens on those individuals and agencies given the responsibilities of implementing a particular procedure or official action. A shift may be occurring in the values placed on these competing interests. Organizations have sprung up in some states (e.g., North Carolina, Wisconsin) advocating the interests of family members of

respondents in seeing that respondents are not released from inpatient care and treatment. Members of these groups are frustrated with the "revolving door" of many hospital facilities and the lack of community resources, and have effectively advocated for lengthier hospitalization and tighter requirements for release of respondents to communities unprepared to accept them. Althought the trend is clear, the impact on the courts is not.

> GUIDELINE II-DD. THE COURTS SHOULD ENCOURAGE ATTORNEYS FOR RESPONDENTS TO DETERMINE WHETHER THEIR CLIENTS WHO HAVE REQUESTED CONVERSION TO VOLUNTARY ADMISSION STATUS, HAVE DONE SO KNOWINGLY AND WILLINGLY.

Comment

Nowhere are the concerns about release and diversion from compulsory inpatient hospitalization so dramatically highlighted than on the issue of conversion of respondents from involuntary to voluntary status. Guideline II-DD suggests a mechanism whereby the courts may influence and regulate the conversion to voluntary status, without excessive interference with a central concern of mental health facilities.

It is generally acknowledged that significant benefits accrue from patients being voluntary rather than involuntary, if admission is, in fact, voluntary. The respondent may receive theraputic and legal advantages from a decision to elect voluntary admission to the hospital. The respondent who recognizes his or her need for treatment in a hospital, and seeks it voluntarily, may be more likely to benefit from treatment. Voluntary status generally brings more privileges and a more satisfying experience as a patient. Further, by electing voluntary admission to the hospital before any hearings have occurred, the respondent avoids the stigma of compulsory hospitalization, the commitment case will be dismissed, and, in most states, all court records will be expunged. Traditionally, voluntary status engenders considerably less paperwork and legal involvements for hospital staff. Much time is saved by avoiding hearings and reports to the courts. The status conversion debate centers on three concerns: (1) the abuse of the involuntary-to-voluntary-status-procedure by involuntary patients unsuitable for voluntary status in order to "sign themselves out" of the hospital; (2) the alleged coercion of involuntary patients by mental health facilities to convert to voluntary status; and, (3) responses and solutions to these concerns that are so complex or onerous that they are unworkable or place an undue burden on attorneys or mental health personnel (see Part IV, Chapter Two). Similar concerns can be raised about other mechanisms for prehearing release and diversion.

The purpose of Guideline II-DD is to assure that the respondent has had an opportunity to consider the consequences of conversion to voluntary hospitalization, without unnecessarily intruding on the hospital's ability to conduct its affairs to the best of its compacity.

> GUIDELINE II-EE. (1) ONCE A RESPONDENT'S PREHEARING RELEASE OR DIVERSION HAS BEEN JUSTIFIED IN ACCORD WITH

LEGAL PROVISIONS, AND ON THE BASIS OF DETERMINATIONS MADE BY MENTAL HEALTH PERSONNEL THAT THE RESPONDENT NO LONGER REQUIRES COMPULSORY HOSPITALIZATION, THE MENTAL HEALTH FACILITY HOLDING THE RESPONDENT SHOULD EXPEDITIOUSLY EFFECT THE RESPONDENT'S RELEASE OR DIVERSION.

(2) COURTS SHOULD ENSURE THAT PARAGRAPH (1) IS IMPLEMENTED.

Comment

Becuase of a fear of liability for unpredictable violence by a released or diverted involuntary patient, or because of a feeling that a respondent has a "right" to his or her day in court, mental health professionals may retain a respondent in a hospital involuntarily, contrary to the intent of law, to the interests of the respondent, and to their own professional responsibilities. Guideline II-EE provides that the courts should regulate the release policies of mental health facilities if such policies cause unwarranted involuntary commitment. As a practical matter, this guideline could be implemented, albeit slowly, by admonishing, or otherwise advising, mental health personnel who express their application of such policies in testimony during judicial hearings.

GUIDELINE II-FF. COURTS SHOULD REQUIRE THAT MENTAL HEALTH AGENCIES PROVIDE NOTICE OF THE RELEASE OR DIVERSION OF A RESPONDENT TO INDIVIDUALS WHO MAY BE INCONVENIENCED BY ATTENDING A SCHEDULED JUDICIAL HEARING OF THE CASE (E.G., WITNESSES, ATTORNEYS), AND TO AGENCIES WITH A LEGITIMATE INTEREST IN THE CONTINUING CARE AND TREATMENT OF THE RESPONDENT.

Comment

Although release or diversion from involuntary hospitalization serves the respondent's liberty interests, and although the respondent no longer meets commitment criteria, the respondent may still need some type of mental health care or treatment. Referral to community services may serve this need. A link to contingent mental health services, for person released from involuntary hospitalization, appears to be lacking in many places. For example:

> The members of one PET [Psychiatric Emergency 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 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 symptons 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 ... should be referred to the community mental health centers for voluntary mental health services. (Los Angeles, pp. III-5, 6).

PART III

RESPONDENT'S COUNSEL

Contents

INTRODUCTION

This part addresses significant court concerns regarding respondent's counsel. It is generally accepted that respondents in involuntary civil commitment proceedings have a right to be represented by counsel. Legislatures and courts have recognized that the civil commitment process may not always operate adequately to protect the interests and rights of the persons subject to it. The deprivation of liberty and the social stigmatization that typically result from involuntary psychiatric treatment have provided the impetus for providing many of the legal protections ordinarily associated with the criminal justice process, including the right to appointment of counsel.

Respondent's counsel is a critical ingredient in the involuntary commitment amalgam. Before the hearing, counsel is responsible for explaining legal rights and options available to the respondent. Whether the hearing court receives a complete picture of the respondent's condition and is able to arrive at a thoughtful and appropriate disposition depends largely on the performance of the respondent's attorney. The attorney who fully explores his or her client's needs, legal options, and available treatment options, can do much to ensure adequate protection of a respondent's rights and interests.

Chapter One of this part addresses the appointment of counsel, including for whom counsel should be appointed, and the mechanics and criteria of appointment. Chapter Two considers the role of respondent's counsel, that is, whether counsel acts as advocate or guardian ad litem for the respondent, or in some middleground capacity. Chapter Three concerns counsel's functions throughout the involuntary civil commitment process. Because these functions are particularly intertwined with materials addressed in others parts of the Provisional Guidelines, only selected concerns are addressed here. Cross-reference is made to supplementary sections of the Provisional Guidelines, where additional concerns are addressed in context.

CHAPTER ONE

APPOINTMENT OF COUNSEL

THE LAW

For Whom Counsel is Appointed

Many statutes require appointed counsel for indigent respondents. Indigency ordinarily is the basis for providing appointed counsel. In some states, the indigency determination is made by the clerk or magistrate responsible for issuing a custody order, based on information obtained from the petitioner (e.g., North Carolina). In other states, the indigency determination may be made by the court (e.g., Iowa). Indigency is not necessarily the only basis for appointment of counsel. One state's statute requires appointed counsel not only if a respondent is indigent, but if a respondent refuses to retain counsel. Several jurisdictions have adopted this procedure as a matter of practice. Such a procedure protects persons who may be financially capable of employing an attorney, but mentally incapable of intelligently deciding whether to employ one.

Few state statutes address whether a respondent may reject the assistance of appointed counsel. At least one statute specifically provides that, with the court's consent, a respondent may act pro se (e.g., Illinois). Generally, a respondent's waiver of the right to counsel must be made "knowingly, intelligently, and voluntarily." In actual practice, courts are reluctant to recognize a respondent's waiver as being valid. During the Institute project, staff observed that when a respondent requested to not be represented by counsel, courts sometimes responded by requiring that counsel remain at the hearing. Counsel could assist the respondent if requested, or "if necessary". In Chicago, if a respondent wishes to represent him or herself, a court may direct a public defender to provide legal assistance if the respondent later requests help.

Mechanics of Appointment

The great majority of states provide for the appointment of counsel in the early stages of the commitment process, usually when petitions (e.g., Texas) or physicians' reports (e.g., North Carolina) are first filed. In several states, counsel must be appointed within a specified time before the hearing (e.g., six days in West Virginia). In Virginia, counsel need not be appointed until after a preliminary hearing (in practice the full hearing often immediately follows the preliminary hearing).

Counsel generally is appointed by a magistrate (e.g., Iowa), a court clerk (e.g., North Carolina), or a court (e.g., Illinois). Attorneys generally serve on a rotating basis. If a jurisdiction has a public defender or other similar advocacy system, these attorneys generally represent respondents. In other jurisdictions, counsel is

selected from a list of private attorneys in the community. In Columbus, Ohio, attorneys serve a six week assignment; that is, they receive cases for a six-week period each year. In other states, attorneys are assigned sequentially from the list. This is the practice in Winston-Salem, North Carolina, except that the clerk may assign particularly difficult cases to attorneys particularly suited for such cases. Also in Winston-Salem, the clerk may at one time assign an attorney three cases at the same hospital; this maximizes time and fees, and provides incentive for the attorney to visit the clients before their hearings. Articulated criteria for removing attorneys from the list of potential appointees seem not to exist.

Criteria for Appointment

Ordinarily, to qualify for appointment, private attorneys need only be licensed to practice law in the state. Attorneys in a public defender's office may be assigned to a mental health division on the basis of interest and personal experience.

GUIDELINES

For Whom Counsel is Appointed

> GUIDELINE III-A. (1) WITHIN THE CONSTRAINTS OF APPLICABLE STATUTE, COUNSEL SHOULD BE APPOINTED FOR ALL INDIGENT RESPONDENTS, AND FOR ALL RESPONDENTS WHO EITHER FAIL OR REFUSE TO RETAIN COUNSEL, REGARDLESS OF FINANCIAL ABILITY.
>
> (2) UNLESS A RESPONDENT IS INDIGENT, OR UNLESS THE COMMITMENT PETITION IS DISMISSED OR DENIED, THE RESPONDENT SHOULD BE REQUIRED TO REIMBURSE THE REASONABLE COST OF APPOINTED COUNSEL. A REGULAR METHOD SHOULD BE ESTABLISHED TO DETERMINE WHETHER A RESPONDENT IS INDIGENT.
>
> (3) IF A RESPONDENT WISHES TO WAIVE THE RIGHT TO COUNSEL AND PROCEED PRO SE, THE COURT SHOULD DETERMINE WHETHER THE PURPORTED WAIVER IS MADE KNOWINGLY, INTELLIGENTLY, AND VOLUNTARILY. AFTER A VALID WAIVER, THE COURT MAY REQUIRE THAT COUNSEL STAND BY TO ASSIST THE RESPONDENT IF REQUESTED OR IF NECESSARY.

Although the currently prevailing practice is to appoint counsel only for indigent respondents, the guideline requires appointed counsel not only for indigents, but also for all respondents who either fail or refuse to retain counsel, regardless of ability to pay for an attorney. This ensures that respondents financially capable of employing an attorney, but mentally incapable of intelligently deciding whether to employ one, will nevertheless be provided the protection needed, given the grave threat to their personal liberty. Further, appointing counsel for all respondents should facilitate the appointment process. Requiring an indigency determination before each appointment can delay the

appointment of counsel. The added cost of appointed counsel for non-indigent respondents is addressed by the guideline.

Part (2) of the guideline provides that a financially capable respondent should be required to reimburse the cost of appointed counsel, unless the petition is dismissed or denied. Requiring a respondent to pay for an unrequested attorney may seem unreasonable and, possibly, illegal. The guideline specifically exempts from the reimbursement requirement all respondents who are subject to unmeritorious commitment petitions. Implicit in the reimbursement requirement is the assumption that a respondent, had he or she been mentally capable of intelligently deciding whether to retain counsel, would have retained counsel, given the grave threat posed by the potential commitment to his or her liberty. The fees which must be reimbursed under the guideline are only those fees which are reasonable for protection of the respondent's liberty interest.

Indigent respondents also are exempted from the reimbursement requirement. Who makes the indigency determination is often decided by statute or by local practice. Who makes the determination is probably unimportant, so long as the determination is made regularly and early in the commitment process.

Part (3) of the guideline recognizes that even if a valid waiver has occurred, as a practical matter, a respondent may be unable to proceed pro se (see Part IV, Chapter Four, for discussion of the criteria for a valid waiver). Thus, the guideline would have the appointed attorney remain available in the courtroom so that he or she may assist the respondent if the respondent subsequently so requests. Further, if after permitting a respondent to proceed pro se, the court determines that counsel "is necessary" to the progress of the hearing, the court may direct counsel to assist the respondent. Counsel should receive an appropriate fee for remaining available in the courtroom.

Timing of Appointment

> GUIDELINE III-B. UPON ACCEPTANCE OF A VALID PETITION AND OF A TEMPORARY-DETENTION ORDER, THE JUDICIAL OFFICER RESPONSIBLE FOR HANDLING THE INITIATION OF COMMITMENT PROCEEDINGS SHOULD APPOINT COUNSEL FOR A RESPONDENT.

The guideline requires appointment of counsel for a respondent at the initiation of commitment proceedings. Appointment of counsel is required at that time not merely to allow the attorney adequate time to prepare for the hearing, but to ensure that a respondent's interests are protected in the prehearing period. For example, an attorney might assist a respondent in seeking a voluntary admission (see Part II, Chapter Five, and Part IV, Chapter Two), or a less restrictive treatment alternative (see Part V, Chapter Two). Also, an attorney might seek release or diversion of a respondent in an appropriate case (e.g., if the respondent no longer meets the commitment criteria) (see Part II, Chapter V). Traditionally, the focus of appointment concerns has been on

preparation for hearing. The guideline recognizes that this concern is important, but that a respondent has an independent need for representation in the prehearing portion of the commitment process.

Appointment of Private Attorneys

> GUIDELINE III-C. (1) IN JURISDICTIONS WITHOUT A PUBLIC DEFENDER OR SIMILAR ADVOCACY SYSTEM, A JUDICIAL OFFICER SHOULD BE RESPONSIBLE FOR ESTABLISHING AND MAINTAINING A LIST OF PRIVATE ATTORNEYS WHO ARE POTENTIAL APPOINTEES. THE OFFICER MIGHT BE THE PERSON WHO ACTUALLY APPOINTS COUNSEL UNDER GUIDELINE III-B.
>
> (2) THE COURT SHOULD ESTABLISH FAIR CRITERIA FOR INCLUDING ATTORNEYS IN THIS LIST, AND FOR REMOVING ATTORNEYS FROM THE LIST.
>
> (3) THE COURT SHOULD REQUIRE ATTORNEYS TO PARTICIPATE IN AN ORIENTATION PROGRAM AS A PREREQUISITE TO INITIAL INCLUSION IN THE LIST, AND A CONTINUING EDUCATION PROGRAM AS A PREREQUISITE TO CONTINUED INCLUSION IN THIS LIST.
>
> (4) JURISDICTIONS USING PRIVATE COURT-APPOINTED COUNSEL SHOULD STUDY AND CONSIDER USING ALTERNATIVE SYSTEMS FOR PROVIDING COUNSEL IN INVOLUNTARY CIVIL COMMITMENT CASES.

The guideline requires that private attorneys appointed under the prescribed procedure participate in orientation and continuing education programs. The initial orientation could be as simple as a one-to-one meeting between the judge and the new appointee, to discuss expectations, and to clarify and expand on any written requirements. Another approach would be to videotape a seminar held to initiate the orientation program, and to present the videotape to attorneys subsequently added to the appointment list. Similarly, the seemingly rigid continuing education requirements could be made much more flexible by use of videotapes of periodic seminars. The value *per se* of such seminars should be self-evident: continuing discussion of the judges' and attorneys' roles, mutual discussion and problem-solving concerning the difficulties that arise in the day-to-day operations of the system, and presentation and implementation of modifications to meet the needs of an everchanging commitment process. The content and operation of the educational program should be a joint effort of the judiciary, the local bar, and the local mental health system.

Part (4) of the guideline recommends that jurisdictions using private court-appointed counsel should consider alternative systems. Various systems in different states provide counsel for indigents in commitment hearings. These include the use of a public defender, the use of special advocates responsible exclusively or primarily for commitment cases, and the assignment of private attorneys available locally. Private assignment systems often result in less effective advocacy.

Private attorneys appointed to cases on an occasional basis typically have little expertise in the area of mental health law. Furthermore, because attorney compensation is relatively low, relatively new attorneys having little legal experience often take these cases. As a result, attorney competency may be lower than in jurisdictions using nonprivate defender systems.

CHAPTER TWO

ROLE OF COUNSEL

THE LAW

Statutory mandates concerning the role and responsibilities of respondent's counsel vary widely in number and specificity. Most state statutes fail to prescribe the role of counsel with any specificity. Many statutes give only a general directive such as "assist in preparation of a petition for habeas corpus" or "represent the respondent at proceedings." North Carolina statute provides that the role of appointed counsel should be the same as the role of privately retained counsel. More specific statutory directives require appointed counsel to meet with the respondent within one day of appointment and to explain respondent's rights (e.g., Oklahoma); to review reports and to interview the petitioner, the testifying physicians, and the petitioner's supporting witnesses (e.g., Arizona); to investigate alternatives to court ordered treatment (e.g., Arizona); and to secure witnesses for the respondent (e.g., West Virginia). Several statutes address appointed counsel's post-commitment role, requiring counsel to perfect an appeal and to provide "all representation" until the respondent is discharged (e.g., North Carolina); and to investigate and pursue patient abuse claims (e.g., Ohio, New York).

In the absence of a state statute that adequately prescribes the role and responsibility of respondent's counsel, two alternative approaches are possible. First, the judiciary might promulgate rules delineating minimum standards for effective assistance of counsel in involuntary civil commitment cases. At each hearing, the court might inquire concerning a given attorney's compliance with these minimum requirements. Second, a group of attorneys, such as the local or state bar, might promulgate rules concerning peer education and review.

GUIDELINES

> GUIDELINE III-D. IN HELPING TO SHAPE THE PROPER ROLE OF COUNSEL, A COURT SHOULD ENCOURAGE ATTORNEYS TO CONSIDER THE REALITIES OF THE MENTAL HEALTH-JUDICIAL SYSTEM, INCLUDING STRAINED RESOURCES AND THE NEED FOR COOPERATIVE STRATEGIES.

The guideline recognizes that a detailed prescription of the role of a respondent's counsel engenders risks of controversy. Attorneys new to the civil commitment system, however, need guidance concerning their proper role. In the absence of general guidelines, new attorneys might needlessly go through lengthy experimenting until they find a role that is acceptable and workable in practice. At a minimum, general guidelines should reflect the current practices in the jurisdiction. These guidleines could become the basis both for orientation of new attorneys, and for discussion of the attorney's role, as the climate in the legal and mental health communities changes.

Two approaches have traditionally been taken to the role of counsel. The majority of commentators have taken the position that the proper role of counsel in commitment proceedings is that of an advocate for the respondent's wishes, as the respondent defines those wishes (usually respondents want prompt discharge from the hospital and dismissal of the case). In this role, counsel does not substitute his or her own personal judgment for the expressed wishes of the respondent. At the other extreme, an attorney may assume the role of guardian ad litem, acting in what he or she perceives to be the best interests of the respondent (this may be discharge from the hospital, as the respondent wishes, or continued custody and care, contrary to the respondent's wishes, but congruent with the attorney's perception of the respondent's needs).

Under the guideline, neither of these traditional approaches is generally preferable. The attorney's role need not be forced into one or the other of the traditional forms. Rather, the attorney's role should be that which works most effectively in the particular locality, given the demands of the particular respondent's situation. Thus, for a respondent who is apparently competent to make decisions effecting his legal status, an attorney might assume an advocate stance, in the purest sense. On the other hand, an obviously incompetent respondent might require a "best interests" approach. In many cases, a more workable middleground would require counsel not merely to confront the mental health system as an adversary, nor to abandon his or her client's liberty interest and pursue the client's best interests, but to work with the mental health system in reaching a proper resolution of the client's case.

In practice, the traditional forms of counsel's role rarely occur in their pristine forms. An attorney's performance as an aggressive advocate may vary depending on what he perceives will be acceptable to the particular judge before whom he is to argue. Also, the assumption of a role may be tempered by the condition of a particular respondent. Finally, the stage of the proceedings may determine the nature of counsel's role. For example, in the initial stages of the proceedings an attorney might assume the role of advocate for release of the respondent. That is, in the absence of contrary information the attorney might assume that immediate release of the respondent is the desired goal toward which representation should be aimed. The attorney may relax the advocacy stance, however, if an independent examiner determines that the respondent definitely needs immediate, compulsory hospitalization.

Each local commitment system tends to develop a norm in practice, tending toward one side of the role dichotomy. In influencing the role of counsel, a court should recognize the predominant practices in the locality, and determine how they might be streamlined. The goal is to enhance coordination and cooperation between respondents' counsel and the mental health system.

Although neither traditional role is generally preferable over the other, a consideration of the merits of each may be helpful in determining the best approach for a particular jurisdiction. The

theoretical bases of the dichotomy between the advocate and "best interests" roles is perhaps best exemplified by focusing on a respondent's liberty interests, on the one hand, and his or her need for (or right to) treatment, on the other hand. Best interests proponents assert that the individual's valid need for treatment is at least as strong as the right to be free from involuntary treatment. This argument assumes that the involuntary civil commitment system is the best means for providing psychiatric treatment to needy individuals, and that a traditional adversary system will fail to identify and provide commitment for truly needy individuals. Most psychiatrists agree that because involuntary patients are generally less favorably disposed toward treatment than are voluntary admittees, therapy is less likely to be successful. Thus, even if a person truly needs treatment, commitment may not be the best alternative.

Best interests proponents assert that the commitment respondent, because of his of her mental illness, cannot know his or her own best interests and, thus, counsel must ascertain and pursue these interests for the respondent. The advocate perspective, however, points out that mental illness and incompetence are not synonymous; indeed, most states explicitly deny a presumption of incompetence from a finding of, or treatment for, mental illness. Recent studies have shown quite convincingly that psychiatric predictions of future dangerous behavior are terribly unreliable -- that predictions of dangerousness much more frequently are wrong than they are right. Given the difficulty psychiatrists have in assessing respondents' suitability for commitment, it is unrealistic to think that respondents' attorneys can know what is in their clients' best interests. This is particularly true in cities where appointed attorneys usually are inexperienced in mental health matters.

An adversary role would leave such decisions with a proper authority. Lawyers are specially trained and suited for the zealous advocacy of their clients' stated wishes. The specifics of this role can be found in the Code of Professional Responsibility, in case law on requirements of counsel in both delinquency and commitment proceedings, and (by negative implication) in cases charging ineffective assistance of counsel. Just as the defender of a possibly guilty client must give the best possible assistance, so a respondent's counsel must perform his or her accustomed role. The adversary attorney is but one weight on the scales of justice; the attorney's interaction with other participants in the mental health-judicial system should lead to a proper resolution of a commitment case.

Best interests proponents assert that the adversary role allows an attorney to ignore other valid concerns. For example, the advocate may focus exclusively on effecting a respondent's release, disregarding the respondent's possibly vital need for psychiatric help. Also, the litigious advocate is antithetical to the humane aspirations of the mental health system. In fact, it is said that the adversary process is inherently antitherapeutic, subjecting a respondent to unhealthy stresses that should be avoided when a person is thought to be ill enough to be brought into the commitment system.

On the other hand, to say that a lawyer should strongly present a case for release, if the respondent so desires, is not to say that the attorney should forego the critical process of sensitive exploration of the respondent's true desires. This process includes extensive counseling concerning the options available within the commitment system, weighted according to the attorney's view of probable success and beneficial results for the respondent. Only in reasonable interactions with family, petitioners, and law enforcement and treatment personnel, can the attorney get a true picture of all the viable options. Lawyers are well aware of the benefits of amiable relations with their "adversary", with a view towards settlement, right up to crossing the threshhold into the courtroom. If this attitude pervades the pretrial process, and if appropriate decorum is observed during hearings, advocacy should not be per se destructive or stressful. In fact, both psychiatrists and patient groups suggest that the respondent having his or her day in court can be the first stage in facing and ameliorating the difficulties that precipitated the commitment attempt.

A sound theoretical base for counsel's role may be important, but actual practice must determine the role which is best in a particular locality, for a particular respondent. Above all the system must be workable. By understanding the need for coordination and cooperation rather than confrontation, and by communicating this need to counsel, judges can facilitate the functioning of the mental health-judicial system.

CHAPTER THREE

FUNCTIONS OF COUNSEL

THE LAW

Preparing the Case

The province of the judge traditionally does not include inquiry into adequacy of an attorney's preparation of a case, much less supervision of that preparation. On the other hand, it is the judge's ultimate responsibility to ensure the fair and accurate presentation of both sides of a case, so that the adversary process maximizes the probability of exposing the truth. Just as the court's role in shaping the role of counsel is essential to the proper functioning of the mental health-judicial system (see Chapter Two), the court's role is essential in assuring that counsel is adequately prepared. Only by having a basic knowledge of what constitutes minimum acceptable performance, and by requiring conformance to these minimums, can a judge meet his or her responsibilities in a civil commitment case.

It is beyond the scope of the Provisional Guidelines to detail all aspects of the adequate preparation of the respondent's case for a commitment hearing. The reader is referred to the extensive treatment of this topic in the Mental Disability Law Reporter's three-part Practice Manual: Preparation and Trial of a Civil Commitment Case, 5 MDLR 3, 4, 5; this manual was originally published in 1979 by the ABA Commission on the Mentally Disabled; it was written by Franklin J. Hichman and Richard Abrams for the Bar Advocacy Project of the Cleveland Legal Aid Society. This three-part manual also contains selected portions from Steven Schwartz and Donald Stern's Trial Manual for Civil Commitment (Mental Health Legal Advisors Committee, 294 Washington Street, Boston, Massachusetts 02108). See, also, Hyde and Darby, Civil Commitment in Ohio--A Manual for Respondents' Attorneys (Ohio Legal Rights Service, 1980); Andalman and Chambers, Effective Counsel for Persons Facing Civil Commitment: A Survey, A Polemic, and a Proposal, 45 Miss. L.J. 43 (1974), Part III at 50; Leonard, Defense Counsel's Role in the Commitment Process, Appendix to "Supreme Court Study Commission on the Mentally Disabled and the Courts," Civil Commitment in Minnesota (1979). Discussion here is limited to judicial influence in two phases of case preparation: information gathering and meeting with the respondent.

Those systems that utilize a public defender or similar agency system seem to maximize the probability that counsel will consistently research available information sources for both background and treatment options data. Individual attorneys in private appointment systems, however, may be as well-prepared as any counsel. The level of attorney preparation often varies more by individual rather than by whether an attorney is in public or private practice. Perhaps more continuous involvement and greater familiarity with the system, could explain why public attorneys tend to prepare more adequately than private attorneys. Of course, all counsel are limited by the short time between appointment

and hearing. Also, a particular client's situation may inherently limit the information available.

Another factor complicating an attorney's ability to prepare is the availability of information. Although few hospitals seem to block attorney access to hospital records, some statutes extend confidentiality and consent restrictions to respondents' counsel. Another form of treatment data which counsel should seek is the "pre-screening" examination. Although pre-hearing examination and treatment universally are performed, the results of these often are not available to a respondent's attorney in time to allow meaningful assessment or use in preparing the case. At times, even though the examination is sufficiently in advance of hearing, hospital staff may be unavailable to respond to counsel's questions. Finally, some attorneys also have difficulty obtaining court records concerning the respondent. Desired data might include previous criminal records, previous commitment records or even petitions, affidavits, or other data relevant to the then-current commitment.

Attorneys may have insufficient time to allow meaningful interaction with a respondent. During the Institute project, staff observed a range of preparation from a few-minute conference in the courtroom, to two or more meetings at a treatment facility between custody-taking and the hearing. Variations in respondent's condition was a major factor in determining the success of these meetings. A court's role in facilitating attorney preparation involves helping to remove these and other hinderances to preparation.

The Hearing

Significant court concerns regarding counsel's role at hearing are addressed here and elsewhere in this report. Specific guidelines regarding counsel appear in Parts IV and V. Also in those parts is more detailed treatment of respondents' rights and interests underlying counsel's responsibilities. Here, and in the corresponding guidelines, selected concerns are addressed, (i.e., presence of the respondent and others, jury trial concerns, evidentiary matters, and hearing record concerns), and cross-reference is made to supplementary sections of the Provisional Guidelines.

In some jurisdictions, a respondent's counsel may request the respondent's absence, or may actually waive the respondent's right to be present, in two situations: if the respondent unequivocally demands to not attend, or if the respondent is so disturbed that his or her attendance would either cause further and serious emotional upset, would irreparably injure the respondent's chances for release or less restrictive placement, or would completely disrupt and prevent a meaningful proceeding. Respondents seldom demand to be absent from the hearing. If a respondent makes such a demand, the attorney should carefully inquire into the respondent's motivation. It may be that the respondent's ignorance of the proceeding's nature has produced unreasonable fears that counsel can allay through sensitive discussion.

The very disturbed respondent presents a more difficult situation. The court should be aware that an attorney may be reluctant to submit an already disturbed client to the possible stresses of a formal hearing. This reluctance may be increased if others, especially treatment personnel, suggest that the respondent should not attend. Yet, an attorney's lack of expertise in treatment matters may mitigate against court reliance on this protective, best-interests role (see Chapter Two). Counsel's lack of ability to analyze and predict respondent's behavior also mitigates against acceptance of counsel's judgment that a respondent's presence would disrupt the proceedings.

When the respondent is present at hearing, a concern arises regarding the effects of psychotropic medication on the respondent's appearance and demeanor. A critical part of counsel's case preparation is to ascertain the types and effects of treatment being administered to respondent in the prehearing period. This information must be translated into the subjective effects on respondent's level of functioning. These effects should be brought to the court's attention. Some progressive statutes require mental health professionals to inform the court of the residual effects of chemotherapy. Respondent's counsel should see that the court has this information whether or not statutorily mandated.

Counsel's concerns about the presence of others at the hearing can be summarized in terms of two impacts: the impact on the respondent, and the impact on respondent's case against involuntary commitment. A respondent's counsel should assure the availability of all witnesses necessary for the fullest and most advantageous presentation of the respondent's case. Although many statutes provide subpoena power to respondent's counsel, others do not specifically so provide. Some statutes permit submission of affidavits by examiners and by treatment personnel in lieu of personal appearance. This occurs frequently in practice even in absence of a statutory provision.

It is not uncommon for the initiating petitioner to not attend the hearing. Family members may be reluctant to testify due to fears of retribution from the respondent. Finally, even if witnesses are available, the lack of meaningful access to these individuals in the prehearing preparation could negate the benefits of their testimony.

Jury trial issues are more extensively dealt with elsewhere in this report (see Part IV, Chapter Four). This paragraph briefly discusses counsel's concerns about jury trials. A request for a jury generally lengthens the prehearing period. The increased efforts and longer prehearing incarceration required may be unjustified by any benefits to the respondent. In Columbus, Ohio, jury trials are rarely held. When they are held, the outcome is rarely different than in a bench trial. Conversely, in Los Angeles, California, respondent's lawyers state that they almost always get their client released when tried before a jury. In Los Angeles, however, the standard of proof for a jury trial is "beyond a reasonable doubt." Further, convening a jury trial involves no longer prehearing hospitalization than a bench hearing. In summary, it seems that the decision whether to demand a jury (where available) is reached by balancing the increased procedural

details and potential for longer prehearing hospitalization against the perceived improvement in a respondent's chances for release.

Several state statutes provide that the rules of evidence for civil trials should be followed in commitment hearings. More frequently, statutes are silent on the subject. Even if the formal rules apply, respondent's counsel seldom utilizes them to the fullest extent possible. Various reasons may explain this: some lawyers may fear irritating a judge who may not desire a full-blown adversary hearing; some, particularly those who follow a best-interests model of representation, may feel that numerous objections would be disruptive or would not improve their client's case significantly, or that it would be inappropriate to have a respondent released on a technicality.

Posthearing

Two issues arise concerning counsel's posthearing role: whether counsel for the commitment hearing continues to represent the respondent in the posthearing phase, and what role the court plays in supervising this continued representation when it occurs. Some statutes expressly provide respondent's counsel with posthearing responsibilities (e.g., North Carolina). Duties may consist of merely considering and perfecting an appeal of the commitment decision, or may be a general responsibility for meeting the respondent's legal needs throughout the period of involuntary treatment. Several states have a "patient advocacy system" to serve patient's legal needs (e.g., New York). In some of these states, the advocacy begins at prehearing and continues through the period of commitment; in others, the advocacy services begin only after involuntary hospitalization is ordered. In the latter case, the need for information-sharing and general coordination between the hearing and posthearing lawyers is crucial. Finally, many states do not specify counsel's posthearing duties. Even though legal representation may be provided for appeals or recommitment hearings, statutes do not state if the original hearing counsel will perform this function or if new counsel is appointed. Regardless of the statutory handling of these matters, in those jurisdictions without a formal patient advocacy system, the universal practice is merely to pursue commitment appeals.

Where a formal patient advocacy system takes over a committed patient's case, the committing judge has little responsibility for or control over the performance of advocacy duties. By contrast, if the hearing counsel continues to act after commitment, the judge has at least the responsibility for seeing that appointed counsel fulfills his or her duties. In either case, the judge may have continuing jurisdiction over the respondent, and thus, over both the respondent's mental health treatment and any legal representation. Several states mandate periodic progress reports to the court, or at least allow the court discretion to require periodic reports.

GUIDELINES

Preparing the Case

GUIDELINE III-E. (1) A HEARING JUDGE SHOULD INQUIRE WHETHER THE RESPONDENT'S ATTORNEY HAS ADEQUATELY PREPARED THE CASE. IF LIMITED AVAILABILITY OF INFORMATION OR INSUFFICIENT TIME PREVENTS ADEQUATE PREPARATION, THE COURT SHOULD ENCOURAGE COOPERATION BETWEEN COUNSEL AND INFORMATION SOURCES, SUCH AS TREATMENT PERSONNEL.

(2) COUNSEL SHOULD HAVE TIMELY ACCESS TO ALL TREATMENT AND DIAGNOSTIC RECORDS RELATING TO THE RESPONDENT. IF SUCH ACCESS IS PROVIDED FOR BY STATUTE, A SIMPLE PROCEDURE SHOULD BE DEVELOPED AND PROMULGATED DESCRIBING A METHOD FOR OBTAINING SUCH RECORDS.

(3) COUNSEL SHOULD HAVE TIMELY ACCESS TO ALL COURT RECORDS RELATING TO THE RESPONDENT. A PROCEDURE FOR ACCOMPLISHING THIS ACCESS SHOULD BE DEVELOPED AND PROMULGATED.

(4) THE COURT SHOULD MAKE KNOWN TO ALL THE PARTICIPANTS IN THE COMMITMENT PROCESS, THAT IT ENCOURAGES COOPERATION WITH THE RESPONDENT'S COUNSEL IN PREPARATION OF THE CASE.

Comment

Part II of the Provisional Guidelines encourages coordination and cooperation among the various units of the mental health-judicial system. Guideline III-E addresses a specific area in which this coordination and cooperation is important. After reviewing the allegations which initiated the commitment proeedings, counsel should have an opportunity to talk with the petitioner, the respondent's family, any prospective witnesses, and any examining or treatment personnel. Further, counsel should have an opportunity to personally meet with the respondent sufficiently in advance of the hearing to gather background information, and to prepare a plan for presentation of the case.

Part (1) of the guideline addresses generally the court's responsiblity for encourageing treatment personnel and others to cooperate with counsel in case preparation. Parts (2) and (3) address specific materials which should be made available to counsel. Part (4) reiterates the vital need for cooperation.

The Hearing

GUIDELINE III-F. RESPONDENT'S ATTORNEY SHOULD NOT BE PERMITTED TO WAIVE A RESPONDENT'S RIGHT TO ATTEND THE HEARING EXCEPT IN EXTRAORDINARY CIRCUMSTANCES. THE

COURT SHOULD MAKE SPECIFIC FINDINGS OF FACT CONCERNING THE REASONABILITY OF A REQUEST FOR RESPONDENT'S ABSENCE.

Comment

Guideline III-F reflects the strong policy in favor of the respondent's presence at hearing. This guideline addresses the limited circumstance of counsel's waiver of the respondent's right to be present. Guideline IV-I, paragraph (1) (in Part IV, Chapter Four), addresses the respondent's waiver of that right. Guideline III-F requires the court to make findings of fact concerning the responsibility of counsel's waiver, and to allow a waiver only in extraordinary circumstances. What constitutes extraordinary circumstances is left to court discretion. Guideline IV-I, paragraph (1), requires that counsel certify to the court that a respondent's waiver was made knowingly and voluntarily. This certification may relieve, but does not prevent, the court from inquiring into the reasonability of the waiver.

GUIDELINE III-G. A RESPONDENT'S ATTORNEY SHOULD ADVISE THE COURT OF WHETHER THE RESPONDENT IS UNDER THE INFLUENCE OF PSYCHOTROPIC MEDICATION AND OF ANY RESULTING EFFECT ON THE RESPONDENT'S DEMEANOR, APPEARANCE, OR ABILITY TO EFFECTIVELY PARTICIPATE AND ASSIST COUNSEL.

Comment

This guideline expresses a responsibility reciprocal to that expressed in Guideline IV-I, paragraphs (2) and (3). The court must inquire concerning possible effects of psychotropic medication, and, when possible, should not permit a respondent to be under the influence of psychotropic medication. Counsel must advise the court concerning whether the respondent is under the influence of medication, and concerning any effect of that medication on the respondent's conduct at the hearing. Why these reciprocal responsibilities are important is discussed in Part II, Chapter Four, and Part IV, Chapter Four.

GUIDELINE III-H. RESPONDENT'S COUNSEL SHOULD ADHERE TO THE RULES OF EVIDENCE APPLICABLE IN CIVIL PROCEEDINGS, UNLESS OTHERWISE SPECIFIED. IF CONCLUSORY OR BASELESS OPINIONS ARE UNCHALLENGED BY COUNSEL, THE JUDGE SHOULD EXERCISE DISCRETION TO PURSUE A FULLER EXPLICATION OF DIAGNOSES OR OTHER OPINIONS.

Comment

Evidence issues may be viewed at two levels. At the technical level, respondents deserve the benefit of every legal protection that a state legislature has provided for them. Relevancy and hearsay rules, for example, are intended to assure that the state presents reliable evidence in its case to involuntarily commit a respondent. The rules are

effective, however, only if a respondent's counsel vigorously objects to non-complying evidence. A pertinent example is the use of prior-commitment evidence by testifying examiners. Not only might hearsay problems arise with pre-commitment treatment records, but the relevance of these records to the current commitment situation is also highly questionable. (See Guideline IV-K, paragraph (2), and corresponding commentary). Such data may have a major impact on the decision to commit.

The second level of the evidence issue is substantive. Even if an expert witness testifies concerning his personal observations, counsel's job is not finished. Many witnesses present testimony which is conclusory, containing unexplained diagnostic terminology. This practice is pervasive: from initial petitions merely parroting statutory language, through screening diagnoses such as "schizophrenia-chronic, undifferentiated." (See Part II, Chapter Four, for a discussion of this issue in regard to mental health examiners' reports to the court). Counsel's failure to challenge such conclusory assertions is damaging not only to the respondent's case against commitment, but to the court's ability to reach a well-informed and proper decision. It is incumbent upon respondent's counsel to present the facts in a form that will assist the judge in reaching a just result. If, however, counsel fails to fully meet this responsibility, the court should exercise discretion and pursue an explanation of the facts underlying a witness' conclusory statements. This may be accomplished either by encouraging counsel to question the witness further, or by the court itself questioning the witness. The federal courts, and many state courts, allow judges to question witnesses, "in the interests of justice." Because it is the court's duty to assure a full and fair presentation of the evidence, the court can and should exercise its discretion. See Guidelines IV-J and IV-K which further address evidentiary concerns.

> GUIDELINE III-I. (1) IF NOT STATUTORILY REQUIRED, THE MAKING OF A RECORD SHOULD BE AVAILABLE ON REQUEST OF RESPONDENT OR RESPONDENT'S COUNSEL.
>
> (2) ORIENTATION AND CONTINUING EDUCATION OF RESPONDENT'S COUNSEL, AS PROVIDED IN GUIDELINE III-C, PARAGRAPH (3), SHOULD INCLUDE DISCUSSION OF ISSUES CONCERNING THE HEARING RECORD, GIVING SPECIAL ATTENTION TO COUNSEL'S NEED TO SEEK AND ASSURE THE USE OF PROTECTIVE SAFEGUARDS SUCH AS SEALING AND EXPUNGEMENT.

Comment

To facilitate a respondent's ability to effectuate an appeal of a court's commitment decision, the court should honor a request that a record of the hearing be made. Orientation and continuing education of attorneys eligible for appointment in commitment cases should include discussion of concerns addressed in part (2) of the guideline. See Guidelines IV-N and IV-O which address record making and expungement issues.

Further guidelines pertaining to court concerns regarding counsel's responsibilities at hearing include Guidelines IV-B, paragraph (4) (duty to explain hearing notice to respondent); IV-E, paragraphs (1) and (2) (duty to certify that respondent is advised of the right to request voluntary admission, and of the procedures for and consequences of exercising that right); IV-F, paragraph (1) (duty to certify that respondent's request for voluntary admission is made knowingly and voluntarily); IV-L (duty to certify that respondent's waiver of right to jury is made knowingly and voluntarily); and IV-M, paragraph (2) (duty to explain to respondent the right to request a closed hearing).

Posthearing

GUIDELINE III-J. (1) THE COURT SHOULD DEVELOP AND PROMULGATE SPECIFIC GUIDELINES CONCERNING THE POSTHEARING RESPONSIBILITIES OF RESPONDENT'S COUNSEL, AS WELL AS PROCEDURES TO IMPLEMENT THESE GUIDELINES.

(2) EVEN IF THE CASE IS TAKEN BY AN ADVOCACY AGENCY, COUNSEL SHOULD BE RESPONSIBLE FOR INFORMING THE CLIENT OF ANY RIGHT TO AN APPEAL SO THAT ANY STATUTORY FILING LIMITS CAN BE MET; SIMILARLY, COUNSEL SHOULD BE RESPONSIBLE FOR SHARING WITH THE ADVOCATE THE FRUITS OF COUNSEL'S CASE PREPARATION.

Comment

The posthearing responsibilities of counsel may be shaped to some extent by applicable statute. Promulgating counsel guidelines may consist of delineating the parameters of a statutory mandate for continued representation. The precise responsibilities of counsel depend largely on local practice. The court should ensure that respondents' counsel understand their function and perform it adequately. Counsel's function might include perfecting an appeal, monitoring a treatment facility's periodic reporting to the court, seeking less restrictive treatment alternatives, or even assisting with respondents' legal concerns which are unrelated to the commitment process (e.g., contracts, domestic concerns).

Part (2) of the guideline provides that hearing counsel should be responsible for informing the respondent of any right to appeal. Further, hearing counsel should provide posthearing counsel with information which may be helpful in facilitating posthearing representation. These responsibilities should help smooth the counsel transition and should enhance cooperation and linkages as discussed in Part II of this report.

PART IV

HEARING CHARACTERISTICS

Contents

Page

INTRODUCTION

This part of the Provisional Guidelines discusses characteristics of and circumstances surrounding the judicial hearing held to determine whether to involuntarily commit a respondent for an extended period. Whether this hearing is mandated by statute or held at the respondent's request, the manner in which it is conducted is crucial to the ultimate commitment decision. This part is relevant only to the threshold question of whether to involuntarily commit the respondent. Although in practice the adjudication of commitment and treatment issues may be difficult to divide, for the sake of exposition and better understanding of the hearing process, the adjudication of treatment concerns in the formal hearing will be considered separately and in detail in the following part.

Each of the four chapters addresses specific aspects of the hearing process. Chapter One addresses when and where the hearing must be held, who must receive notice of the hearing, and who should preside over the hearing. Chapter Two concerns whether a respondent may request voluntary admission in lieu of commitment, whether such a request may be denied, and what legal and treatment consequences result from a voluntary admission. Chapter Three discusses the criteria a court should apply, and the manner in which the parties should present related evidence, in determining whether a respondent should be involuntarily committed. Further, the allocation of the burden of proof, and the standard of proof, are discussed. Finally, the importance of alternative treatment modalities is considered. Chapter Four addresses who must be, and who may be, present at the hearing, what rules of evidence and procedure should be followed, whether the case may be heard by a jury, and whether a verbatim hearing record should be made and maintained.

A few matters important to the hearing process are dealt with in other parts of the Provisional Guidelines. Most important among these are counsel's role at the hearing, and treatment planning. Although this part includes discussion and guidelines concerning counsel, Part III deals more extensively with the appointment and function of counsel. Similarly, although treatment concerns are addressed here only briefly, the reader should consult Part V for a discussion of treatment issues during judicial hearing.

CHAPTER ONE

HOLDING HEARINGS

THE LAW

Mandatory Hearings

Most states mandate a hearing before an individual may be committed involuntarily for an extended period. A few (e.g., California, New York) require a hearing only if it is requested by the person to be committed.

From the "liberty" perspective, mandatory hearings provide the best protection against a person being committed unnecessarily: mandatory hearings serve as a check against slack screening procedures and help to assure the individuals involved that they are being treated fairly. From the "helping" perspective, mandatory hearings may limit the time which psychiatrists and hospital personnel can devote to treating patients. Moreover, when the petitioner is someone close to the respondent or is the physician treating the respondent, requiring a courtroom confrontation may retard the respondent's recovery.

Because of both the deprivation of liberty and the unfortunate social stigma associated with involuntary commitment, mandatory hearings are generally preferred over hearings upon request. The burdens imposed by mandatory hearings can be reduced through the availability of the pre-hearing screening procedures described in Part II, and a voluntary admissions procedure with adequate safeguards against abuse (see Chapter Two).

Hearing Upon Request

Those statutes which provide for a hearing upon request vary with regard to who may request and to whom a request may be made. Possible requestors, in addition to the respondent, include a relative, friend or counsel (e.g., New York). Requests may be delivered to the court, through the clerk's office, through a member of the staff of the mental health facility in which the respondent has been placed, or through the individual who provides notice of the right to a hearing (e.g., California).

Permitting numerous individuals to request a hearing and multiple routes of access to hearings provides protection against a respondent's being "lost in the system." Although such provisions entail the danger that a hearing may be initiated against the respondent's wishes and may require greater than usual flexibility in court administrative procedures, these costs are outweighed by the possibilities of infringement on individual liberty and the expense to the public of unnecessary hospitalization.

Request procedures should be as simple as possible. Detailed information (e.g., names and addresses of persons to notify) and the precise allegations needed to satisfy statutory and court administrative requirements can await entry of counsel into the case and need not be required to initiate the proceedings. In order for a system of hearings by request to serve as an effective safeguard, the procedure must assure that all involuntarily

committed persons receive notice of their right to a hearing, and a comprehensible explanation of the hearing-request procedures. In addition, hospital staff to whom an individual indicates a desire for a hearing must be obligated to submit a request to the court. Further, it is essential that an adequately funded system provide respondents with competent counsel no more than 48 hours after a petition has been filed (see Part III, Chapter One).

Timing of Hearing

Statutes concerning the timing of a hearing vary along two dimensions: the time which may elapse prior to a hearing, and the event from which this time period is to run. The triggering event may be the filing of the petition (e.g., Arizona), the taking of the defendant into custody (e.g., North Carolina), or the filing of a request (e.g., New York). The time between the event and the hearing may be as short as two days and as long as 30 days.

Determining how much time should elapse before a hearing is required involves balancing several considerations. On the one hand is the respondent's interest in being released quickly if detention is unjustified. On the other is the need to provide sufficient time for the respondent to be properly examined and for each side in the proceeding to adequately prepare. If prehearing treatment is prohibited, there is the additional concern of authorizing needed treatment expeditiously. When prehearing treatment is permitted, there is the countervailing factor of giving the respondent an opportunity to recover without incurring a record of an involuntary commitment.

A five day period triggered when a respondent is taken into custody appears to provide the proper balance. In most jurisdictions, five days should provide an adequate opportunity for examination of the respondent. The screening procedures outlined in Part II should limit substantially the detention of individuals who are able and willing to receive treatment on a voluntary basis or who do not require treatment. To permit more extensive preparation, the respondent should be permitted to request a continuance of the hearing for up to 10 days. Care should be taken, however, to assure that this opportunity for a continuance is not used as an excuse for assigning an inadequate number of attorneys to represent indigent respondents.

Notification Requirements

Statutes vary considerably in specifying who is to receive notice of the hearing, what the notice should contain, and how it is to be presented. Most states provide for notice to be given to the respondent, to a close relative or guardian, and to the individual's attorney(s). Some require that notice be provided to the Department of Mental Health or to the local community mental health facility (e.g., California, West Virginia). A few specify that the petitioner be notified of the hearing (e.g., Indiana, Ohio), that notice of the filing of a petition or of a hearing be given to the local prosecutor (e.g., Michigan), or that notice must be sent to two or three persons named by the respondent or the court (e.g., Illinois, New York).

With regard to the content of the notice, many statutes require that the petition be attached to the notice. Some add the supporting affidavits of petitioner(s) (e.g., Arizona). Others specify that the notice include a list

of the respondent's rights (e.g., Oklahoma, West Virginia). The timing of the notice ranges from 14 days to 48 hours before the hearing. Most statutes fail to address the means for delivering notice in involuntary civil commitment cases. This omission suggests that the methods used to provide notice in civil cases apply to commitment proceedings. None of the statutes examined assigned responsibility for providing notice.

The purpose of a notice requirement is to advise interested parties of a pending action or proceeding, and to provide information and time necessary to permit those parties to present their objections, if any. Without an effective notice procedure, the commitment process is subject to delay and challenge.

As indicated above, current statutes provide insufficient guidance regarding the distribution and contents of notice of the commitment hearing. Individuals with roles in the hearing, including those concerned with placement and treatment, should receive notice of the hearing. Respondents should receive a written explanation of the hearing's purpose and of their rights (if such an explanation has not been previously provided). Delivery to the respondent should be effected either through a member of the hospital staff who is able to provide at least a general explanation of the documents, or through the respondent's attorney. Counsel should be obligated to personally explain these matters to the respondent. Other lay participants in the proceeding should also receive the explanation of purpose together with the name and telephone number of an individual they may call for further information and explanation. The court should be responsible for issuing notice. The time limits for notice should allow for sufficient preparation before the hearing.

Place of Hearing

Those statutes which address the issue, generally provide some flexibility concerning the location of the hearing. Hearings may be held in a courtroom, in the judge's chambers, or at a mental health facility. Some also permit the hearing to be held at the respondent's home or another "suitable place not likely to have a harmful effect on the person's health or well-being" (e.g., Indiana). Others prohibit holding the hearing in a regular courtroom if the respondent objects and "a more suitable place is available" (e.g., North Carolina).

Like the decision regarding the timing of the hearing, selecting the hearing site requires a balancing of conflicting interests. For judges, attorneys, and court personnel, the most convenient location is the courthouse. Psychiatrists, psychologists, and other members of the treatment staff greatly benefit from having the hearings at the hospital. Doctors and other professional staff intensely dislike traveling to a courtroom, waiting for judges to arrive, waiting for their case to be called, and possibly doing this to no avail if a continuance is issued. The intrusion on treatment staff time is considerably less if hearings are held within their treatment facility.

The interests of respondents are less clear. If the hearing is held at the facility, respondents are spared the indignities and discomfort of supervised transportation to, and confinement in the courthouse, in what can be an intimidating courtroom setting. In a facility-based proceeding,

however, unless care is taken to assure that judicial decorum is maintained both in the setting and conduct of the proceeding, the hearing may appear confusingly like a treatment conference. Because treatment staff do not regularly attend hearings in jurisdictions that hold commitment hearings in the courthouse, the respondent's opportunity to confront and cross-examine key witnesses is enhanced by holding the hearing at the hospital. On the other hand, some facilities tend to discharge cases in order to avoid sending staff and patients to hearings at the courthouse.

The flexibility demonstrated in current practice should be maintained with the paramount concerns being minimization of risk to the respondent and minimization of inconvenience to the court and hospital staff. When hearings are held in the hospital, care should be taken to assure that the setting for the hearing maintains the dignity and formality of a courtroom.

Presiding Officer

Authority to preside over commitment hearings is generally granted to a judge. In some states this authority is granted to judges of the court of general jurisdiction (e.g., Arizona). In others, judges of courts of limited jurisdiction hear commitment cases (e.g., Ohio). Some states permit quasi-judicial officers (referees, commissioners, special justices) to preside over commitment hearings (e.g., Virginia).

The arguments regarding who is to preside over the commitment hearing focus on the status, prestige, expertise of the official, and the use of judicial resources. It is contended that because the respondent's liberty is at issue, commitment proceedings should be accorded the importance, visibility, and accountability, that result from having a judge preside. Conversely, it is suggested that because, in most jurisdictions, commitment hearings require only a small percentage of a judge's time and atttention, most judges will not develop a detailed understanding of the legal and psychological principles involved in commitment hearings. Thus, a quasi-judicial officer, whose primary judicial assignment is mental health proceedings, would be more likely to become an expert and to give the proceeding the attention it deserves. These researchers observed no particular advantage to having hearings conducted by judges rather than quasi-judicial officers. The differences in knowledge, attitude, and practice among those who preside over these hearings, is apparently not correlated with status. Judges who are new and those who rotate in and out of the commitment case calendar, however, are usually less conversant with mental health law and procedure than those who hear such cases regularly and repeatedly.

Whether a judge or a non-judicial officer presides over commitment hearings, provision should be made to assure that the presiding official understands the jurisdiction's mental health laws, is familiar with the technical terms and principles, knows of the array of available local mental health treatment facilities, and is able to render fair and impartial decisions.

GUIDELINES

Provisions for Holding Hearings/Timing

GUIDELINE IV-A. (1) A HEARING SHOULD BE HELD NO MORE THAN FIVE (5) DAYS AFTER A PERSON HAS BEEN TAKEN INTO CUSTODY OR A PETITION FOR INVOLUNTARY CIVIL COMMITMENT HAS BEEN FILED, WHICHEVER OCCURS FIRST. A REQUEST FOR A HEARING BY THE RESPONDENT SHOULD NOT BE REQUIRED.

(2) ORDINARILY, CONTINUANCES FOR REASONABLE PERIODS, IF REQUESTED BY THE RESPONDENT, SHOULD BE GRANTED. EXCEPT IN EXTRAORDINARY CIRCUMSTANCES, CONTINUANCES REQUESTED BY OTHER PARTIES SHOULD NOT BE GRANTED OVER THE RESPONDENT'S OBJECTION.

Comment

The guideline follows the Illinois statute by recommending that the full hearing be held within 5 days for all persons subject to involuntary civil commitment. This recommendation is premised on the establishment of stringent prehearing screening procedures (see Part II) to identify and divert most of the individuals who can be adequately served by community mental health facilities or who do not require treatment. It is also premised on the availability of properly safeguarded voluntary admission procedures (see Chapter II) for those able and willing to consent to treatment. In this way, commitment hearings will be limited to those cases in which there is disagreement over the need for or the capacity to consent to hospitalization. Given the liberty interests threatened by involuntary commitment, and the limited treatment resources available, requiring hearings in these relatively few cases is both necessary and proper. Limiting the number of cases through the means above will also enhance adherence to the proposed five-day time limit.

As noted above, the respondent may seek to postpone the hearing for a number of reasons: to arrange for an independent examination, to arrange for voluntary treatment alternatives, to secure the presence of a particular witness, to recover from a physical illness, or to recover sufficiently from the mental illness to obviate the need for involuntary commitment. Because the likelihood is slight that many respondents who are in custody will abuse the availability of continuances, hearing postponements sought or concurred in by such respondents should be granted as a matter of course. Because of the strong public interest in a prompt determination, as well as the burden imposed on the respondent by delay, it is recommended that continuances should not be granted if the respondent objects, except in highly unusual circumstances (e.g., the examining psychiatrist is ill on the day of the hearing).

Notification Requirements

GUIDELINE IV-B. (1) PROCEDURES SHOULD BE ESTABLISHED SO THAT THE DATE, TIME, AND PLACE OF A HEARING MAY BE SET NO MORE THAN ONE DAY AFTER THE PETITION IS FILED.

(2) THE COURT SHOULD ISSUE NOTICE OF THE HEARING IMMEDIATELY AFTER THE HEARING HAS BEEN SCHEDULED. BY THE MOST EXPEDITIOUS MEANS AVAILABLE, THE NOTICE SHOULD BE SENT TO THE RESPONDENT, A CLOSE RELATIVE OR GUARDIAN OF THE RESPONDENT, TO THE RESPONDENT'S ATTORNEY, THE PETITIONER AND HIS OR HER ATTORNEY IF ANY, THE ATTORNEY REPRESENTING THE STATE, THE DIRECTOR OF THE FACILITY IN WHICH THE RESPONDENT IS HOUSED, AND TO ANY OTHER INDIVIDUAL WITH A DIRECT INTEREST IN THE PROCEEDING.

(3) IN ADDITION TO THE DATE, TIME AND PLACE OF THE HEARING, THE NOTICE SENT TO THE RESPONDENT AND TO THE PETITIONER SHOULD CONTAIN AN EXPLANATION OF THE PURPOSE AND POSSIBLE CONSEQUENCES OF THE HEARING. THE RESPONDENT'S COPY SHOULD ALSO CONTAIN AN EXPLANATION OF HIS OR HER RIGHTS AT THE HEARING. ALL EXPLANATIONS SHOULD BE PHRASED IN NON-TECHNICAL TERMS.

(4) THE COURT SHOULD IMPOSE A DUTY ON RESPONDENT'S COUNSEL TO PROVIDE TO THE RESPONDENT AN ORAL EXPLANATION OF THE MATTERS CONTAINED IN THE NOTICE.

Comment

Given the strict five-day time limit recommended for commitment hearings, it is imperative that the hearing be scheduled and notice issued and delivered as quickly as possible. Thus, the guideline suggests that an expedited procedure be established by the administrative judge, the court administrator, or the court clerk, for setting a time and date for a hearing, and for issuing notice when a commitment petition is filed.

The guideline then recommends that notice be delivered, by the speediest means available, to all persons with a direct interest in the proceeding. Although the formal notice should be in written form, key participants who are familiar with the process, such as respondent's and petitioner's counsel, the attorney for the state, and the facility director may be notified by telephone. (If the respondent is not represented by counsel, the filing of a petition should similarly trigger an expeditious appointment process.)

Two forms of notice are required. Persons presumed to be familiar with the commitment process need only be advised of the date, time, and place of the hearing. The petitioner and respondent are to be advised of the hearing's purpose and possible consequences (e.g., discharge or treatment including possible hospitalization for a specified period of time). If the respondent has not already received a copy of the petition, a copy should be attached to the hearing notice. The guideline cautions that the explanation of purpose and possible consequences should be presented in lay terms. Furthermore, it urges that the respondent's attorney be obligated to provide an oral explanation of the notice, including the purpose and possible consequences of the hearing, and the respondent's rights. When, because

of language differences, illness, or disability, the attorney cannot provide this explanation directly, arrangements should be made to have it presented in the language and mode of communication that the respondent is most likely to understand. That some respondents will not be able to comprehend the information, no matter how well it is explained, does not mean that no effort should be made to involve respondents in commitment proceedings to the greatest extent possible.

Place of Hearing

GUIDELINE IV-C. (1) UNLESS THE RESPONDENT OBJECTS, HEARINGS MAY BE HELD IN A TREATMENT FACILITY.

(2) HEARINGS NOT HELD IN A REGULAR COURTROOM SHOULD BE CONDUCTED IN A ROOM OF ADEQUATE SIZE, WITH SUFFICIENT DIGNITY AND FORMALITY TO ELICIT THE CUSTOMARY RESPECT AFFORDED COURT PROCEEDINGS.

Comment

Permitting hearings to be held at a mental health facility has several advantages. It limits the logistical problems of transporting respondents to the courthouse and of confining them once in the courthouse. It facilitates the attendance of psychiatrists and hospital staff at the hearing. Also, to some extent, it minimizes both the apprehension and discomfort of respondents. Added burdens to court personnel can be somewhat reduced if court personnel travel together to and from the hospital.

The dignity of the court, however, should not be compromised for the sake of convenience. Thus, following the Massachusetts Standards of Judicial Practice for Civil Commitment Proceedings, the guideline urges that the setting befit the seriousness of a proceeding in which an individual's liberty is at issue. As stated in the commentary to the Massachusetts guidelines:

> Judges should wear robes and the hearing room should, at a minimum, contain an appropriate area for the Judge, counsel, the respondent and witnesses to sit. The hearing room should, whenever possible, contain those furnishings normally found in a courtroom. The purpose of such formality is not to inhibit or intimidate a respondent, but rather to remind all parties that a formal court proceeding has commenced... . Informal physicial settings in commitment hearings, where they have been allowed to exist, have often appeared to foster other procedural informalities which would be clearly unacceptable in most court proceedings. [Emphasis in original]

Presiding Officer

GUIDELINE IV-D. (1) IF A JUDGE DOES NOT PRESIDE OVER COMMITMENT HEARINGS, THE PRESIDING OFFICER SHOULD BE AN ATTORNEY, APPOINTED BY THE COURT, VESTED WITH THE LEGAL AUTHORITY TO ISSUE NECESSARY ORDERS, AND ABLE TO DECIDE IMPARTIALLY THE MATTERS PRESENTED.

(2) JUDGES AND ATTORNEYS PRESIDING OVER COMMITMENT HEARINGS SHOULD BE CONVERSANT WITH THE STATE MENTAL HEALTH LAWS AND PROCEDURES, THE CONSTITUTIONAL PRINCIPLES APPLICABLE TO MENTAL HEALTH PROCEEDINGS, AND THE AVAILABLE TREATMENT PROGRAMS. COMMITMENT HEARINGS SHOULD BE A REGULAR PART OF THEIR DUTIES BUT NOT THEIR ONLY JUDICIAL DUTY.

Comment

Given the seriousness and complexity of the issues involved in commitment proceedings, it may be preferable to have a judge preside over commitment hearings. Our legal system relies on judges to hear and decide other types of proceedings in which liberty and the exercise of governmental authority over individuals are at issue. Commitment hearings deserve no less.

If because of limited judicial resources it is necessary to rely on non-judicial decisionmakers, the guideline suggests that the presiding officer be an attorney. Although medical concerns are often the focus of a commitment hearing, the paramount issue is a legal one -- the exercise of the government's police and welfare powers over an individual. The guideline also stresses that an attorney acting as a hearing officer should be cloaked with the necessary authority and be free from obvious conflicts of interest such as serving as counsel to a mental health department or facility. Finally, the guideline makes clear that before presiding over a commitment proceeding, judges and attorneys must familiarize themselves with the issues, procedures, and alternatives which they will face. In order to facilitate such an understanding, commitment hearings should be more than merely an occasional assignment. On the other hand, to provide the requisite perspective and to avoid dulling routinization, the guideline urges that presiding over commitment hearings should not be a full time, long-term assignment.

CHAPTER TWO

OPPORTUNITY FOR VOLUNTARY ADMISSION

THE LAW

Right to Request Voluntary Admission

Most, but not all statutes permit persons subject to involuntary civil commitment to seek voluntary admission to a mental health facility. Some make the respondent's refusal to accept voluntary treatment a prerequisite to filing an involuntary commitment petition (e.g., California). Others provide voluntary admission as an option at the respondent's (e.g., Arizona, Illinois, New York) or hospital's (e.g., Michigan) initiative.

From both the liberty and helping perspectives, voluntary admission has advantages. Persons voluntarily admitted generally have more freedom within the facility and are able to effect their release more easily than if they were involuntarily committed. They also avoid the continuing stigma of an involuntary commitment. Moreover, because voluntary admittees are generally more favorably disposed toward treatment programs, therapy is more likely to be successful. In addition, treatment staff avoid the paperwork and hearings required for involuntary commitment.

Thus, whether to permit voluntary admissions is not the major issue. The important issues are what safeguards are needed to protect the respondent against coerced or unknown consent to voluntary admission, and what safeguards are needed to prevent respondents from using voluntary admission procedures to avoid treatment.

Notice of Right

Most statutes do not address whether notice of the right to seek voluntary admission must be provided to a respondent. Those which do require notice fail to address how notice is to be given and what it is to include (but cf. Illinois).

Given the advantages of voluntary admissions, the question again is not whether to require notice, but how. Should notice be given by the respondent's counsel, by the staff of the treatment facility, by the court, or by some combination? To what extent should the treatment options, the discharge policy, and the advantages and disadvantages of voluntary admission vis a vis involuntary commitment, be explained to the respondent? Hospital staff are generally in the best position to explain to the patient the treatment to which he or she would be consenting. Usually, however, they are less familiar with the legal ramifications of voluntary hospitalization. The respondent's attorney is in the best position to explain the differences in respondent's legal rights under a voluntary as opposed to an involuntary status, but is often less conversant with the treatment alternatives. Formal notification at the

hearing ensures that notice is provided, but normally does not provide much opportunity for explanation and questions.

A workable middle ground would be to require the respondent's attorney to certify to the court that the respondent has received notice of the right to request voluntary admission, notice of the procedure for requesting such an admission, and an explanation of the legal and treatment consequences. It would, thus, be incumbent upon counsel not only to explain the legal aspects of the decision, but also to ensure that someone familiar with the available treatment facilities and alternatives has described or shown to the respondent the treatment that he or she might expect following a voluntary admission.

Competence to Consent

Most statutes do not address the level of competence required for a person subject to involuntary civil commitment to consent to voluntary admission. In effect, a respondent is presumed competent until there has been an adjudication of incompetence and a guardian appointed. A few states require that the respondent must be "capable" (e.g., Virginia) or able to understand the consequences of (e.g., New York) accepting voluntary admission. These statutes, however, do not set forth procedure or criteria for determining capacity to consent.

The degree to which a respondent's competence should be considered in approving an application for voluntary admission is a complex issue, especially when considered from a national perspective. It can be argued on the one hand, that many individuals who, because of mental illness, are incompetent to consent to treatment, would meet the criteria for involuntary commitment. Because voluntary admission is more advantageous to all concerned than involuntary commitment, the time and expense required for a judicial determination of competency and appointment of a guardian are unnecessary. Moreover, the constraints on the number of patient beds available and the cost advantages of outpatient treatment make abuse of voluntary admission procedures unlikely.

The opposing argument is that application for voluntary admission is tantamount to a waiver of the respondent's constitutional right to a hearing and to clear and convincing proof that the commitment meets the statutory criteria. Because the respondent's liberty is at issue, any such waiver must be made voluntarily and knowingly. Under this line of argument, when a respondent is not able to understand the nature and consequences of the rights being relinquished and the treatment being accepted, a judicial determination of eligibility for commitment is required. Because commitment has sometimes been used merely as a means of community protection, without the provision of treament, goodwill is not an adequate safeguard against abuse. Mental incompetence should not be considered synonymous with the need for hospitalization.

The New York and Virginia provisions noted above attempt to forge a middle ground relying on the discretion and judgment of the

attorneys, physicians, and judge involved. Without more objective criteria, however, due process and equal protection violation can easily occur.

The certification procedure appears to be a way of protecting against abuse without overly burdening the system. Before dismissing a petition for involuntary commitment because the respondent has decided to consent to admission, the court should require the attorney to certify that he or she has discussed the request with the respondent, and determined that the respondent generally understands the nature and consequences of consenting to treatment and that the respondent is doing so voluntarily. When the attorney is unable to certify that the request was filed knowingly and without coercion, the court should receive evidence and hear argument on the matter at the hearing on the commitment petition. Courts have an obligation to assure that the judicial authority to commit an individual involuntarily is not used to coerce consent to treatment. The certification process appears to be a relatively simple way of accomplishing this purpose. It will require, however, the prompt appointment of counsel whenever a petition for involuntary commitment is filed.

Approval Procedures and Conditions

Statutes vary as to when and by whom a request for voluntary admission may be denied. Many do not address the question at all. Most of those which do, leave the decision to the director of the treatment facility. Others, however, provide a role for the court when a petition for involuntary commitment is pending (e.g., Arizona, Illinois, Michigan). The Arizona statute requires court approval before a voluntary admission can occur. The Illinois and Michigan provisions state that following an application for voluntary admission, the court is to dismiss the involuntary proceedings if the voluntary admission is in "the best interests of the respondent and the public."

A process for reviewing requests for voluntary admissions is important to protect against two types of possible abuses. The first is an abuse by the respondent -- manipulation of voluntary admissions process to escape the consequences of involuntary commitment and treatment. For example, a person might sign in voluntarily, have the commitment petition quickly dismissed, and then sign out of the hospital as soon as possible. While in the hospital as a voluntary patient, he or she could refuse treatment. Because in many instances, a new petition would be filed within a short period, a review mechanism is necessary to avoid burdening the system with repeated petitions and proceedings.

The second type of possible abuse is an abuse against the respondent -- using the voluntary admissions process as a means of hospitalizing an individual for whom a court might order a less restrictive alternative. Although the current fiscal constraints on public hospitals lessen the likelihood of unwarranted hospitalization, the potential for abuse remains.

Accordingly, state statutes should provide explicit authority to the director of mental health facilities to deny requests for voluntary admission, when a petition for involuntary commitment is pending if the facility is unable to provide appropriate treatment to the requesting person or if it appears that the individual is seeking to use the voluntary admission process as a means for avoiding treatment. In addition, the court should require counsel for the respondent to certify that a request for voluntary admission was made knowingly and without coercion. The court should have authority to temporarily enjoin admission when counsel is unable to so certify, and to hear arguments and receive evidence regarding the request at the time of the hearing on the involuntary commitment petition. The court should also be empowered to review a denial of a voluntary admission request at the hearing on the petition and to require that a statement of the facts and reasons which form the basis for the denial be filed by the facility director.

Extraordinary Consequences of Voluntary Admission

To provide an opportunity for the facility director or treating physician to file a petition for involuntary commitment, most statutes permit a treatment facility to detain a person on voluntary status for a brief period after he or she requests release. The maximum detention period varies from three to five days.

These provisions appear to work well in practice. Conversion of a voluntary admission to an involuntary commitment is generally sought only when the treatment staff is convinced the necessity of further hospitalization outweighs the added difficulty of working with an involuntary patient and of the procedural burden of the commitment process. When facility staff have no intention of seeking involuntary commitment, the patient is usually released.

Statutory provisions should limit the detention period to the shortest period necessary to determine whether to file a petition, and to prepare and submit the required documents. Three days appears more than adequate.

GUIDELINES

Notice of Right to Request Voluntary Admission

> GUIDELINE IV-E. (1) AT OR BEFORE THE HEARING ON A PETITION FOR INVOLUNTARY CIVIL COMMITMENT, COUNSEL FOR THE RESPONDENT SHOULD BE REQUIRED TO CERTIFY THAT HE OR SHE HAS ADVISED THE RESPONDENT OF THE RIGHT TO REQUEST VOLUNTARY ADMISSION, AND HAS EXPLAINED THE PROCEDURES FOR REQUESTING ADMISSION AND THE LEGAL CONSEQUENCES OF BEING ADMITTED VOLUNTARILY RATHER THAN BY COURT ORDER. THE ATTORNEY SHOULD CERTIFY FURTHER THAT THE RESPONDENT HAS RECEIVED EXPLANATION OF THE TYPE(S) OF TREATMENT THAT WOULD BE OFFERED FOLLOWING A VOLUNTARY ADMISSION.

(2) IF NO CERTIFICATION HAS BEEN FILED, THE COURT SHOULD BRIEFLY ADJOURN THE PROCEEDINGS AND DIRECT RESPONDENT'S ATTORNEY TO PROVIDE THE SPECIFIED INFORMATION AND EXPLANATIONS.

Comment

As with notice of the hearing, it is recommended that the respondent's attorney should be responsible for alerting the respondent of the option of voluntary admission and for providing an explanation of the effect of such an admission on the right to be released and the right to accept or decline certain forms of treatment, on living restrictions within the hospital, and on the respondent's credit and employment prospects following release. In addition, the guideline would require counsel to ensure that the respondent receives a description of what voluntary treatment may entail. At a minimum, this should include the patient seeing the ward in which he or she will stay, meeting some of the hospital staff, and receiving an explanation of treatments (and possible side effects) that he or she might expect to receive. In this way, the respondent is not only told that an alternative exists, but is also able to learn the advantages and disadvantages of the various options and to ask questions about them. From the liberty perspective, this procedure protects against both unknowing waivers of the respondent's rights and unknowing consent to treatment. From the helping perspective, it is anticipated that such detailed notice will increase a voluntary admittee's amenability to treatment. Placing this responsibility on the respondent's attorney is consistent with the duties of a lawyer to any client under the Code of Professional Responsibility (see EC 7-8). The certification procedure provides a simple, practical, and effective means for assuring that the necessary information is transferred, thereby helping to limit involuntary commitment hearings to persons who are unwilling or unable to consent to admission. As with any type of notice, the explanation should be presented in the language, mode of communication and terms that the respondent is most likely to understand.

Approval Procedures and Conditions

GUIDELINE IV-F. (1) IF A REQUEST FOR VOLUNTARY ADMISSION HAS BEEN MADE BY A RESPONDENT IN A COMMITMENT PROCEEDING, THE COURT SHOULD NOT DISMISS THE PETITION UNLESS COUNSEL FOR THE RESPONDENT HAS CERTIFIED IN WRITING THAT HE OR SHE HAS DISCUSSED THE REQUEST WITH THE RESPONDENT, AND REASONABLY BELIEVES THAT THE REQUEST IS NOT THE RESULT OF THREAT OR COERCION AND THAT THE REQUEST WAS MADE WITH KNOWLEDGE OF THE LEGAL AND TREATMENT CONSEQUENCES.

(2) IF COUNSEL IS UNABLE TO SO CERTIFY, THE COURT SHOULD CONDUCT AN INQUIRY INTO THE CIRCUMSTANCES SURROUNDING THE RESPONDENT'S REQUEST. THIS INQUIRY SHOULD OCCUR, WHENEVER POSSIBLE, AT THE DATE AND TIME SET FOR THE COMMITMENT HEARING. IF THE COURT DETERMINES THAT THE REQUEST WAS KNOWING AND VOLUNTARY,

OR IF THE RESPONDENT RENEWS THE REQUEST AFTER A DISCUSSION OF HIS OR HER RIGHTS AND THE COUNSEQUENCES OF VOLUNTARY ADMISSION, THEN THE INVOLUNTARY COMMITMENT PETITION SHOULD BE DISMISSED. IF THE REQUEST IS NOT FOUND TO HAVE BEEN MADE KNOWINGLY AND VOLUNTARILY, AND THE RESPONDENT DOES NOT EXECUTE A KNOWING AND VOLUNTARY REQUEST FOR ADMISSION FOLLOWING THE INQUIRY, THE COURT SHOULD PROCEED WITH THE INVOLUNTARY COMMITMENT PROCEEDING.

Comment

To protect both the interests of the respondent and the integrity of the mental health-judicial system, some mechanism is needed to make certain that the voluntary admission procedure is not being misused. Although it can be argued that the right of a voluntary admittee to be released on request vitiates any harm that may result from an uninformed, induced, or incompetent consent, reliance on a system which sanctions deceptive practices would invite abuse and undermine the respect and support of both the legal and social service systems. At least three control mechanisms are possible: relying on respondents to raise objections when they conclude that their rights have been violated, requiring judicial review of every decision by a respondent to enter the hospital voluntarily, or introducing a screening procedure to identify those cases meriting judicial scrutiny. The guideline endorses the third option as the means which can provide the greatest protection at the least cost.

Again, reliance is placed on the respondent's attorney. Under the guideline, the attorney would be required to meet with his or her client to ascertain that the respondent was aware that he or she was agreeing to enter or remain at the hospital, and that this agreement was not the product of threats, unrealistic promises, or other forms of coercion. It is anticipated that in most instances, the certification required by this provision will be coupled with the one called for in the preceding section on notice. When, due to the respondent's disability, the effect of medication, or possible improper practices, the attorney is unable to certify that the request is knowing and voluntary, he or she should advise the court of the reasons for not filing the certification. The court should then conduct an inquiry into the matter. Given the brief period between the filing of the commitment petition and the commitment hearing, the guideline provides for the inquiry to be held at the commitment hearing. When the testimony of witnesses not present at the commitment hearing is required, or when the commitment hearing has been continued, the hearing on the request for voluntary admission should be scheduled separately.

Denial of Requests for Voluntary Admission

GUIDELINE IV-G. FOLLOWING DENIAL OF A REQUEST FOR VOLUNTARY ADMISSION MADE BY A PERSON AGAINST WHOM AN INVOLUNTARY CIVIL COMMITMENT PETITION IS PENDING, THE OFFICIAL DENYING THE REQUEST SHOULD BE REQUIRED TO

FILE A STATEMENT WITH THE COURT. THIS STATEMENT SHOULD SET FORTH THE FACTS AND REASONS UPON WHICH THE DENIAL IS BASED. ON MOTION OF THE RESPONDENT, THE COURT SHOULD CONDUCT AN INQUIRY INTO THE DENIAL OF THE REQUEST. IF IT IS DETERMINED THAT THE FACILITY IN UNABLE TO PROVIDE APPROPRIATE TREATMENT TO THE RESPONDENT OR THAT THE REQUEST WAS FILED IN ORDER TO AVOID TREATMENT, THE COURT SHOULD PROCEED WITH THE INVOLUNTARY COMMITMENT HEARING. IF IT IS FOUND THAT THE DENIAL WAS IMPROPER, AND THE RESPONDENT KNOWINGLY AND VOLUNTARILY RENEWS THE REQUEST, THE COULD SHOULD DIRECT THAT THE RESPONDENT BE VOLUNTARILY ADMITTED.

Comment

As noted above, voluntary admission has been used by some respondents as a means of avoiding both civil commitment and treatment. In applying for admission, their only intent is to seek release as quickly as possible. In these cases and in instances in which the particular facility in which the respondent is being detained lacks the type of treatment services that he or she requires, it is entirely appropriate for the facility director to deny a request for voluntary admission. As with any other administration decision, however, some procedure must be provided to assure accountability. Accordingly, the guideline recommends that the facility director or other official denying a request for voluntary admission be required to set forth in writing an explanation of his or her decision. The court or the facility should provide a copy of this statement to the respondent and respondent's counsel. A judicial review of the denial would be initiated only if the respondent requested it at the beginning of the commitment hearing. If the denial of voluntary status is found invalid and the respondent renews his or her request, the facility could be ordered to admit the respondent as a voluntary patient. If the denial is found to have been proper, the hearing on the commitment petition should proceed.

CHAPTER THREE

CRITERIA FOR INVOLUNTARY COMMITMENT

THE LAW

Specific Conjunctive Criteria

Most state statutes provide that for an individual to be involuntarily committed, it must be shown that he or she is mentally ill and either so gravely disabled that he or she is unable to provide for his or her basic needs, or is a danger to him or herself or to others. The precision with which these concepts are expressed varies considerably. Some statutes include only the terms "dangerous" or "gravely disabled," (e.g., Indiana, North Carolina). Others require a showing of a threat, an attempt to inflict harm, or an actual incidence of harm being inflicted (e.g., Arizona, Washington). A few require proof of additional matters, such as, that the individual is likely to benefit from the proposed treatment (e.g., New Mexico) or that no less restrictive alternative exists (Virginia, New Mexico).

In recent years efforts have been made to add specifically to the criteria for civil commitment. These efforts have been in response to the absence of sound empirical evidence that mental health professionals have any special expertise in predicting dangerous behavior, and to questions regarding the use of mental health treatment facilities to assure simply the provision of food, clothing, and shelter. Examples of these proffered additions include detailed definitions of dangerousness requiring recent behavior which threatens or causes serious bodily harm (e.g., Arizona, Washington). Critics of these changes charge that a requirement of an overt act is too restrictive. They argue that patients who allude to dangerous acts without making explicit threats or engaging in explicitly dangerous behavior, may nevertheless present a danger to themselves or others, and that to prohibit their involuntary commitment is to invite tragedy. The currently prevailing opinion, however, appears to be that requiring recent behavioral evidence of dangerousness enhances the accuracy of assessments of dangerousness. Moreover, because threatening behavior is often the impetus for filing a commitment petition, the risk of releasing a potentially dangerous individual because of the absence of threatening behavior appears more related to post-treatment review than to initial commitment.

Another criticism voiced against current commitment provisions is that they do not sufficiently distinguish between the three elements of the involuntary commitment decision: the diagnostic element (Is the respondent really ill?); the predictive (Is the respondent dangerous or unable to care for him or herself?); and the prescriptive (What form of treatment is appropriate?). The failure to distinguish these three elements was manifested in the commitment hearings which Institute staff observed in several project sites.

If the applicable statute fails to provide precise definitions, courts should develop criteria indicating what type of evidence is necessary to demonstrate dangerousness or helplessness. Such evidence may be presented through the testimony of the petitioner or other witnesses. In addition, courts should encourage counsel to relate presented evidence to each of the three legal elements. In this regard, civil commitment cases should be treated as any other proceeding requiring the plaintiff to establish the jurisdictional basis of the claim (i.e., that the respondent is mentally ill), the basis for liability (dangerousness or helplessness), and the basis for the relief being sought (the appropriateness of the proposed treatment).

Time Reference

One area of confusion is whether a respondent must meet the commitment criteria at the time he or she is taken into custody, at the time of the hearing, or both. Current statutes provide no specific guidance concerning this question. If the respondent's condition at the time of the hearing is not considered, an individual who has recovered from an acute psychotic episode may be involuntarily committed even though he or she may no longer meet the legal criteria for commitment. If the respondent's condition prior to hospitalization is ignored, it will be impossible, in many cases, to present clear and convincing proof of dangerousness or helplessness. Thus, at the initial commitment hearing, the court should require the petitioner to establish that the respondent met the criteria for commitment at the time the proceedings were initiated, and that the respondent remains so mentally ill that he or she still would be dangerous to him or herself or others, or unable to fulfill his or her basic needs, if treatment were not administered and he or she were immediately released.

Consideration of Less Restrictive Alternatives

A number of statutes require use of the "least restrictive alternative," that is, treatment in the setting and manner which impinges least upon an individual's liberty, freedom of choice, and bodily integrity, while also accomplishing the appropriate treatment objectives. In some of these jurisdictions, this requirement serves as a prerequisite for commitment (see, e.g., New Mexico, Virginia, West Virginia). In others it is included among the criteria for determining the proper disposition after an individual has been found to be eligible for commitment (e.g., Illinois, Michigan, Ohio).

The inclusion of a least restrictive alternative requirement in the criteria for commitment presumes that commitment and institutionalization are synonymous. Although commitment and institutionalization formerly were considered synonymous in most jurisdictions, this is no longer so in many jurisdictions. In these jurisdictions, involuntary civil commitment encompasses not merely institutionalization, but also the involuntary provision of mental health services in a variety of settings. Given this trend toward a broad definition of involuntary civil commitment, and the provisions recommended above for providing an opportunity to consent to treatment, use of the least restrictive

alternative principle as a threshold requirement appears unnecessary. Moreover, such use adds to the confusion between jurisdictional and treatment issues cited earlier in this chapter. Accordingly, courts are urged, whenever possible, to interpret least restrictive alternative provisions as applying to the type and setting of treatment to be provided to an individual after he or she has been found to be eligible for commitment. (See Part V, Chapter Two, for a more detailed discussion of least restrictive alternative.)

Burden and Level of Proof

Although most current statutes do not explicitly address which party has the burden of persuasion in an involuntary commitment proceeding, it is implicit that this burden falls on the petitioner, or the state in the petitioner's behalf. If this were not the case, the petition would be presumed to be true and the respondent would have to prove that he or she is not mentally ill, dangerous, or helpless. Such presumptions and negative proof requirements are not found elsewhere in American jurisprudence, and are particularly inappropriate in the mental health area.

With regard to the level of proof, that is, the degree of certainty required in order to commit an individual involuntarily, the United States Supreme Court concluded in Addington v. Texas (441 U.S. 418 (1979)) that:

> ...[T]he individual's interest in the outcome of a civil commitment proceeding is of such weight and gravity that due process requires the state to justify confinement by proof more substantial than a mere preponderance of the evidence ... [but] that the reasonable doubt standard is inappropriate in civil commitment proceedings because, given the uncertainties of psychiatric diagnosis, it may impose a burden the state cannot meet and thereby erect an unreasonable barrier to needed medical treatment.

Accordingly, the Court adopted "a middle level of burden of proof that strikes a fair balance between the rights of the individual and the legitimate concerns of the state." The Court held that the "clear and convincing" standard is the minimum standard which will meet due process guarantees. The precise level of proof, so long as it meets the minimum constitutionally required standard, is a matter of state law.

Prior to the Addington decision, many state statutes set clear and convincing proof, or clear, cogent and convincing proof, as the level of certainty which must be attained before involuntarily committing an individual. A few states, (e.g., Massachusetts) require proof beyond a reasonable doubt. In those jurisdictions in which the statutes still contain a preponderance of the evidence standard, courts should recognize the constitutional mandate and require the petitioner or the state to present evidence meeting the Addington standard. Thus, a petitioner should present at least clear and convincing proof that the respondent is

mentally ill, that he or she has engaged in conduct which demonstrates dangerousness or helplessness, and that if treatment were halted, there is good reason to believe that the respondent would still be dangerous or helpless.

GUIDELINES

> GUIDELINE IV-H. (1) A RESPONDENT SHOULD BE FOUND NOT ELIGIBLE FOR INVOLUNTARY CIVIL COMMITMENT UNLESS THE PETITIONER, OR THE STATE ON THE PETITIONER'S BEHALF, HAS PRESENTED CLEAR AND CONVINCING PROOF OF EACH OF THE CRITERIA FOR COMMITMENT PRESCRIBED BY LAW. THE PETITIONER, OR THE STATE, SHOULD DISTINGUISH BETWEEN THOSE ELEMENTS RELATING TO ELIGIBILITY FOR COMMITMENT, AND THOSE RELATING TO THE TYPE OF AND APPROPRIATE SETTING FOR TREATMENT.
>
> (2) FOR A PETITIONER TO DEMONSTRATE THAT, AS A RESULT OF MENTALL ILLNESS, A RESPONDENT IS DANGEROUS, A COURT SHOULD REQUIRE PROOF THAT (a) THE RESPONDENT HAS RECENTLY THREATENED, HAS ATTEMPTED TO INFLICT, OR HAS ACTUALLY INFLICTED SUBSTANTIAL PHYSICAL HARM UPON HIM OR HERSELF OR UPON ANOTHER PERSON, AND THAT (b) THE RESPONDENT IS STILL SO MENTALLY ILL THAT THERE IS A SUBSTANTIAL LIKELIHOOD THAT HE OR SHE WILL INFLICT OR ATTEMPT TO INFLICT SUCH HARM IF RELEASED WITHOUT FURTHER TREATMENT.
>
> (3) FOR A PETITIONER TO DEMONSTRATE THAT, AS A RESULT OF MENTAL ILLNESS, A RESPONDENT IS UNABLE TO PROVIDE FOR HIS OR HER BASIC PHYSICAL NEEDS, A COURT SHOULD REQUIRE PROOF OF (a) OBSERVABLE BEHAVIORS WHICH HAVE RESULTED IN (b) LACK OF SHELTER, FOOD, CLOTHING, OR BASIC HYGIENE, RESULTING IN OR LIKELY TO RESULT IN (c) SERIOUS PHYSICIAL HARM TO THE PERSON. FURTHER, THE PETITIONER MUST DEMONSTRATE A SUBSTANTIAL LIKELIHOOD THAT, WITHOUT TREATMENT, THESE BEHAVIORS WILL CONTINUE.

Comment

Because the topics in this chapter are so closely linked, the proposed procedural guideline has been drafted as a unit rather than as a series of discrete guidelines. The guideline does not attempt to delineate a statutory provision setting forth the substantive criteria for involuntary commitment. Rather, it suggests how to apply many current statutory formulations to enhance the fairness and reliability of the decision-making process.

The guideline places the burden of persuasion on the petitioner or on the state on the petitioner's behalf. This simply makes explicit the current practice in most jurisdictions. The minimum level of certainty necessary for commitment is set at clear and convincing proof in accord with the decision of the United States Supreme Court in Addington v. Texas (441 U.S. 418 (1979)).

To clarify the presentation of evidence by reducing confusion between the eligibility and treatment decisions, the guideline urges that a court should require the presenting party to distinguish between the eligibility elements (the diagnostic and predictive elements) and the treatment (prescriptive) element. Indeed, when a separate treatment hearing is required, as recommended in Part V, evidence regarding treatment alternatives is irrelevant in determining whether the respondent may be involuntarily committed. Because of this recommended distinction, reference to use of the least restrictive alternative is left to Part V, Chapter Two.

Part (2) of the guideline suggests two elements that must be proven to demonstrate that a respondent meets the dangerousness criterion. The first is a factual determination of whether the respondent was dangerous at the time the petition was filed. Evidence of an overt act or explicit threat is required. Absent such a requirement, subjective impressions and opinions might be treated as fact. The second element is whether the respondent would still be dangerous if treatment were halted and he or she were immediately released. This determination requires a prediction of future conduct. It must be acknowledged that professional caution, among other things, has often led to overclassification of individuals as dangerous. Because of the time elapsed and the treatment provided between the time of the petition and the hearing, however, such predictions cannot be avoided. Thus, the guideline requires the presentation of clear and convincing evidence of a substantial likelihood that the respondent would inflict or attempt to inflict serious boldily harm were he or she released without additional treatment. Such evidence might include the nature and circumstances of the pre-petition overt acts, the type and duration of treatment given the respondent following the petition, the intended effect of that treatment (e.g., restaint, elimination of chemical deficiencies, alleviation of acute emotional distress), the past experience of treatment personnel in similar cases, and the respondent's post-petition actions and attitudes. Adoption of the guideline should encourage counsel to focus on the matters actually in issue, thereby assisting the court to make a more well-informed decision.

Part (3) of the guideline takes a similar approach to the issue of helplessness. It would require clear and convincing proof of pre-petition conduct reflecting the respondent's inability to meet his or her basic health and safety needs. Further, the petitioner would have to prove a substantial likelihood that, without treatment, the conduct would continue. The guideline assumes that many individuals may suffer from chronic mental disabilities and may not be helped by currently available treatment methods. They require shelter and humane care, but not necessarily specialized mental health treatment. Community and institutional mental health facilities are a scarce resource which should not be employed merely for shelter care. Guardianship, rather than civil commitment may be a more appropriate remedy for these individuals. It is anticipated that many such cases will be identified and diverted during the screening process outlined in Part II.

CHAPTER FOUR

PROCEDURAL ISSUES

THE LAW

Presence of the Respondent

Most state codes provide a respondent a right to be present at the involuntary commitment hearing (e.g., Arizona, Indiana, West Virginia). Others treat the respondent's presence as a procedural requirement (e.g., Illinois, North Carolina). Many either permit a waiver of the right or provide an exception to the requirement. The grounds for a waiver or an exception are either that the respondent's presence at the hearing would be detrimental to his or her health (e.g., Arizona, Illinois, Michigan), or that the respondent would disrupt the proceeding (e.g., Indiana, Oklahoma). Actual practice varies considerably among the jurisdictions observed during the Institute project. For example, in Winston-Salem and Columbus, the respondent often is absent, but in Chicago and New York, the respondent almost always is present.

Three questions arise concerning the respondent's presence: should it be encouraged; what should be required for a waiver or exception; and what special measures should be used if the respondent is under the influence of psychotropic medication. Arguments favoring the respondent's presence arise from both the liberty and helping perspectives. The respondent's presence is important so that the respondent may assist his or her attorney in assessing and responding to testimony presented. This is particularly true in commitment proceedings because the opportunity for discovery is limited. Furthermore, exposing the respondent to the facts at the hearing and to the hearing process can serve as a "reality testing" experience for the respondent; the respondent's behavior can be a useful and important basis for further therapy. The primary arguments against the respondent's presence are that family members or close friends may be reluctant to testify, that adverse testimony may be emotionally harmful to many respondents, that many respondents are too physically ill to attend the hearing, and that because they are mentally ill, many respondents may disrupt the proceedings. These concerns, however, can be met in most cases without excluding the respondent. Proper prehearing counseling can often reduce, if not eliminate, a respondent's potential reactions to adverse testimony, and witnesses' possible reluctance to testify. Holding the hearing in an appropriate room in the treatment facility (see Chapter One) can substantially reduce the risks to the respondent's physical health that can arise from transporting respondents to and from a hearing at a courthouse. Barring a potentially disruptive respondent from a commitment hearing is no more necessary than barring a potentially disruptive defendant from a criminal proceeding. The Illinois v. Allen (397 U.S. 337 (1970)) standards for removing a disruptive criminal defendant could be effectively used in commitment proceedings. Thus, court procedures can and should encourage and facilitate a respondent's presence.

Turning to the second question, given the importance of the respondent's presence, a court should require that a waiver of the right be made knowingly and voluntarily. Accordingly, notice of the right should be included in the hearing notice, and explained by counsel in the manner suggested in Chapter One. The court should not accept the waiver unless counsel for the respondent certifies in writing, that the respondent is aware of the right to be present, that counsel has discussed this right and its implicatons with the respondent, and that counsel reasonably believes that the waiver is not a result of threat or coercion. In jursdictions where the presence of the respondent is a requirement rather than a right, a court should excuse the respondent only if presence at the hearing would be harmful to the respondent, or if the respondent would be disruptive to the proceedings. Because, as discussed above, these potential adverse consequences can often be greatly reduced or eliminated, a court should encourage the respondent's presence.

The third question concerns the extent to which a respondent may be under the influence of psychotropic medication during the hearing. Medication is often used to calm a respondent, or with the secondary effect of calming the respondent. As a result, a respondent may appear dazed or may exhibit other behavior due to the medication rather than to an actual mental or physical condition. Not only may medication severely impair a respondent's ability to assist counsel, but also drug-related inappropriate appearance or behavior may substantially contribute to a court's decision that the respondent meets the commitment criteria. Whenever possible, a respondent should not be under the influence of a drug which affects his or her appearance or ability to participate in a hearing. Only if administration of that drug is essential to protect the respondent or others at the hearing, and if no less drastic means is available, should a court permit the psychotropic medication influence. If administration of a psychotropic drug is unavoidable, the trier of fact should inquire concerning the effects of the drug, so that the alteration of the respondent's appearance, demeanor, or actions, does not improperly influence the decision-making process.

Presence of Examiners

Despite the significance of the examiner's report, relatively few statutes specify that a psychiatrist or clinical psychologist who has examined the respondent must testify at the commitment hearing. Of those that do, some (e.g., Arizona) require the testimony of two physicians who have personally examined the respondent; some (e.g., Illinois) require the testimony of only one mental-health expert. If testimony of one or more examiners is required, statutes often allow a waiver by respondent's counsel (e.g., Virginia) or by the court (e.g., California). The practice among the jurisdictions observed in the Institute project varies considerably. In Chicago and Columbus, the examining physician(s) testify in almost every case. In Winston-Salem, physicians almost never appear. In some other jurisdictions, one psychiatrist or clinical psychologist testifies at all the cases heard on a particular day.

Having the examiner present gives the parties and the court an opportunity to probe the statements and conclusions in the written report. This probing may be critically important when an individual's liberty depends on definitions, diagnosis, predictions, and prescriptions, which may be subject to intense disagreement. For several reasons, many psychiatrists and clinical psychologists may be reluctant to testify. The first is inconvenience, particularly when hearings are not held in the treatment facility. The time spent traveling to the courthouse and waiting to testify is time away from seeing patients and performing other duties. Second, many mental health experts feel uncomfortable in an adversarial legal proceeding in which their expert opinion is questioned by laymen and they are required to translate technical concepts into lay terms. Third, their role at the hearing is ill-defined: are they to be neutral purveyors of psychiatric facts about the respondent, are they to be advocates for the party who called them to the stand, are they to be merely practitioners treating a patient, or are they to be a combination of these inconsistent roles. Having only one psychiatrist or clinical pyschologist testify resolves some of these conflicts but does not meet the need to question the actual author of the examiner's report. The expert psychiatrist typically would not be as familiar with each respondent as the treating physician.

Accordingly, courts should require at least one of the examining psychiatrists or clinical psychologists to testify at the commitment hearing. To help familiarize mental health professionals with the legal process and their role in it, orientation materials should be made available. In jurisdictions requiring that a respondent be examined by two examiners (excluding the independent examiner requested by the respondent), the second examiner should not be required to testify if the examination reports are in substantial agreement. To encourage and facilitate testimony by the examining physician as well as to reduce strain on the respondent, hearings should be held in an appropriate room in the treatment facility (see Chapter One). Alternatively, some jurisdictions may wish to experiment with telephone, or 2-way, closed circuit television testimony. Although this would be costly to install, it would allow hearings to take place virtually anywhere, court or hospital. Doctors could be called to "take the stand" electronically, on a hospital telephone or a television hookup, only when their testimony is needed.

Presence of Lay Witnesses

Although many current statutes permit testimony of lay witnesses, only a few require testimony from individuals who are acquainted with the respondent (e.g., Arizona), or who have observed the respondent's behavior (e.g., Indiana). Whether a court should require such lay testimony depends on the matter sought to be proved. Lay testimony may be a key in determining whether the respondent can remain in a family or community setting while receiving treatment. Hence, a court should encourage the petitioner and other individuals who have observed the respondent's actions to share that information at the hearing. If the petitioner is seeking to prove dangerousness or helplessness (see Chapter Three), testimony from individuals who have

observed the respondent's actions would be important. If, however, the matter to be proved is the underlying mental illness, lay testimony may be less important.

Right of the Respondent to Present and Cross-Examine Witnesses

Although crucial to the concept of an adversary proceeding, only a few statutes specify that the respondent is entitled to present evidence and subpoena witnesses (e.g., Michigan, Ohio, Virginia), and to cross-examine witnesses presented by other parties (e.g., Idaho, Michigan, North Carolina). Absence of these rights severely impairs the respondent's ability to present his or her version of the case, and to uncover weaknesses in the facts, diagnoses, and opinions, presented by other parties. The prospect of cross-examination may increase the reluctance of some mental health experts and hospital staff to testify. Despite this possible adverse effect, application of the rules of civil procedure and evidence to commitment proceedings should provide the court with the necessary authority to curtail abusive or overly broad cross-examination. Orientation materials explaining the legal process should be made available to physicians, psychologists, and other staff testifying for the first time.

Evidentiary Matters

In most states, although not always specified by statute, the rules of civil procedure apply to commitment proceedings. The primary questions regarding the applicability of the rules of evidence concern the extent to which hearsay evidence is admissible. Hospital records normally fall within an exception to the hearsay rule -- the "official records kept in the normal course of business" exception. More problematic are the observations of hospital staff which are used by the examining psychiatrist or psychologist in forming a diagnosis, but which are not made part of the hospital record. Those states that follow the federal rule regarding the permissible bases for expert testimony (e.g., Arizona, Michigan) permit an expert to testify on the basis of facts or dates "made known to [the expert] at or before the hearing" so long as the information received prior to the hearing is "of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject." Other jurisdictions have more restrictive rules (e.g., New Jersey, Ohio); their application, however, is often dependent upon local practice and timely objection by counsel. Because medical decisions routinely are premised in part upon observations, comments, and opinions, of people other than the testifying expert, excluding expert testimony because of such a hearsay basis seems unrealistic. Stringent enforcement of such an exclusion of evidence would be detrimental to the court and respondent's joint interest in having a full explanation of the diagnosis and prognosis. To ensure that the practice of admitting testimony based upon hearsay is not abused, however, the respondent must be able to subpoena members of the treatment staff with whom the testifying examiner consulted.

Other questions regarding evidentiary matters concern the admission of prior-commitment evidence and evidence of pending criminal

charges. Evidence of prior commitment should be admissible for purposes of diagnosis and treatment planning, but should not be accepted as sufficient evidence that the respondent meets the commitment criteria. Such evidence is absolutely essential to an accurate diagnosis, and to the formulation of an effective treatment plan. A respondent, however, should not be committed substantially on the basis of psychiatric history. This evidence can strongly bias decisions in favor of commitment and should, thus, be used cautiously.

Similar problems arise concerning evidence of pending criminal charges. The existence of pending criminal charges should be inadmissible. Such criminal allegations have not been proven in court and should not be taken as facts to support the contention that the respondent meets the commitment criteria. Such charges are immaterial and may be prejudicial. Evidence of the actual conduct underlying the criminal charge, however, should be admitted. Use of the evidence presentation format suggested in Chapter Three should clarify the relevance, and limit the prejudicial effect of both prior-commitment evidence and evidence of conduct underlying pending criminal charges.

Right to Trial by Jury

Several state codes entitle respondents in involuntary commitment proceedings to request a jury trial. In most of these states (e.g., California, Illinois, New Mexico) this right applies to the commitment hearing. In others (e.g., New York, Virginia), the right to a jury trial applies only if a trial de novo has been requested.

The right to a jury in commitment proceedings is premised upon the grave threat to the respondent's liberty. Despite this serious threat, in those jurisdictions that permit jury trials, this right is infrequently exercised. It is unclear whether respondents fail to request a jury due to inconvenience considerations (jury trials generally are held in the courthouse rather than the hospital), due to privacy considerations, or due to lack of notice of this right. It is also unclear whether a jury or a judge is more likely to commit the respondent. In these jurisdictions, a court should ensure that a respondent has been advised of the right to a jury. Also, the court should make sure that a purported waiver is made knowingly and voluntarily.

Public Access to Hearings

Although this issue provokes strong feelings on both sides, many statutes fail to address whether the public may have access to involuntary commitment hearings. Codes which do establish an access rule, generally entitle the respondent to waive the rule. For example, some states provide for a closed hearing unless the respondent requests (e.g., North Carolina) or permits (e.g., Ohio) an open hearing. In other states, the hearing is open unless the respondent shows good cause to close them (e.g., New Jersey) or unless the respondent so requests (e.g., Wisconsin).

In practice, the only observers in the overwhelming majority of commitment cases, regardless of statute, are family members, witnesses, mental health professionals, and attorneys. Only in cases of great notoriety (e.g., the commitment hearing following a not guilty by reason of insanity verdict in a highly publicized criminal case) is it likely that the general public would want to attend. It is in such cases, however, that a conflict is most likely to arise between the respondent's interest in not publicizing his or her health problems, and the public's interest in monitoring the judicial process.

Of course, courts are constrained by the terms of the applicable statutory provision. If the statute provides the respondent with an option of opening or closing the hearing, the court should ascertain whether the choices available have been explained to the respondent, and whether the respondent has exercised the choice knowingly and voluntarily. Also the statute may create a presumption for or against public access. If hearings generally are open, guidelines should be developed that outline the matters that are generally appropriate or inappropriate for release in the news media.

Record of the Hearing

Some state codes require the making of a stenographic or electonic recording of commitment hearings (e.g., Iowa). Most either do not address the question, or require such records only if the respondent requests a record or if the respondent is not represented by counsel (e.g., Ohio).

The availability of a verbatim record is just as important in civil commitment proceedings as it is in other court proceedings. If a respondent challenges a commitment decision and no record is available, then a hearing must be held which is either a trial de novo, or an evidentiary hearing at which the judge who issued the commitment order may be called to testify. Although requiring a court reporter to be present, or installing a tape recording system, adds to the cost of the commitment process, and although the number of appeals is generally low, the expense, time, and imposition, on court and hospital staff, required by evidentiary hearings or trials de novo, substantially outweigh these additional costs.

Expungement of Records Following Dismissal or Denial of the Petition

Most current mental health codes fail to address how long court records of involuntary commitment hearings must be retained. Reports and other evidence, interim orders, and clerk's entries, must be retained so long as the disposition of the case is unsettled. If a commitment petition is dismissed, however, either because the respondent has consented to voluntary admission, or because the court has found that the commitment criteria are not met, little need remains to maintain a verbatim record.

Because of the possible stigma to the respondent, if a petition is denied or dismissed, all court records relating to the commitment

proceeding that might identify the respondent should be destroyed. Implementation of this policy would not affect the collection and retention of aggregate statistical data regarding the commitment process (e.g., the number of petitions filed, the amount of court time required to hear involuntary commitment matters, or the percentage of petitions granted). Before the records are destroyed, a respondent should have an opportunity to obtain a copy of the order dismissing or denying the petition, and to obtain any other portion of the file. This will enable the respondent to prove that he or she was not committed. Also, a respondent should sign a release of all claims that he or she, as a result of the attempted commitment, might have against any person or agency. Thus, persons who in good faith sought the commitment, or persons who examined or treated the respondent, could not be sued after the destruction of the record.

GUIDELINES

Presence of the Respondent

GUIDELINE IV-I. (1) A RESPONDENT SHOULD BE ENTITLED TO ATTEND ANY HEARING REGARDING THE PETITION FOR INVOLUNTARY CIVIL COMMITMENT. A COURT SHOULD NOT ACCEPT A RESPONDENT'S WAIVER OF THE RIGHT TO BE PRESENT, UNLESS COUNSEL FOR THE RESPONDENT CERTIFIES IN WRITING THAT HE OR SHE HAS DISCUSSED THIS RIGHT WITH THE RESPONDENT, AND REASONABLY BELIEVES THAT THE WAIVER WAS MADE KNOWINGLY AND VOLUNTARILY. A JUDGE SHOULD ONLY REMOVE A RESPONDENT FROM A HEARING IF, AFTER THE JUDGE'S WARNING THAT HE WILL BE REMOVED IF HIS DISRUPTIVE BEHAVIOR CONTINUES, HE OR SHE NEVERTHELESS CONTINUES TO BE SO DISRUPTIVE THAT THE TRIAL CANNOT PROCEED IN AN ORDERLY MANNER.

(2) DURING THE HEARING, RESPONDENTS SHOULD NOT BE UNDER THE INFLUENCE OF PSYCHOTROPIC MEDICATION UNLESS ADMINISTRATION OF THE DRUG IS ESSENTIAL TO PROTECT THE RESPONDENT OR OTHERS FROM SERIOUS BODILY HARM AND UNLESS NO LESS SEVERE MEANS WOULD PROVIDE SUCH PROTECTION.

(3) IF ADMINISTRATION OF PSYCHOTROPIC MEDICATION IS UNAVOIDABLE, THE JUDGE SHOULD INQUIRE CONCERNING THE EFFECTS OF THE DRUG, SO THAT THE ALTERATION OF THE RESPONDENT'S APPEARANCE, DEMEANOR, OR ACTIONS, DOES NOT IMPROPERLY INFLUENCE THE DECISION-MAKING PROCESS.

Comment

The proposed guideline establishes a strong preference for having the respondent present during all court hearings resulting from the filing of a commitment petition. Given the brief time available for preparation, and the subjective nature of much of the information to be presented, communication between respondent and his or her attorney

during the hearing is often critical. Because of embarrassment, physical disability, or severe mental illness, some respondents prefer not to attend, or cannot attend. Hence, a waiver procedure is provided. The guideline urges that counsel be required to explain to the respondent the availability and importance of the right to be present, and to ensure that the respondent is not being threatened or coerced into forfeiting the opportunity to view and participate in the proceedings. This explanation should be part of the notice procedure outlined in Chapter One.

For instances in which a respondent continually disrupts the hearing, the guideline adopts the procedures applicable to criminal defendants. Thus, a respondent may lose the right to be present only if he or she persists in disrupting the proceedings after the judge has warned him or her of the consequences. Once removed, a respondent should be permitted to return as soon as he or she is willing to conduct him or herself "consistently with the decorum and respect inherent in the concept of ... judicial proceedings," (Illinois v. Allen, 397 U.S. 337, 343 (1970)).

> Public confidence in the trial process requires that removal ... be limited to cases urgently demanding that action be taken, that it be done only after explicit warning, that there be a standing opportunity ... to return to the courtroom, and that the burden that absence creates ... be kept to the unavoidable minimum. American Bar Association Standards for the Administration of Criminal Justice: Special Functions of the Trial Judge, 18 (2d ed. Approved Draft 1978).

Part (3) of the guideline recognizes the potential conflicts among preventing disruptive behavior, permitting medical treatment, and allowing the respondent to fully assist in his or her defense. Medication that affects appearance, movement, speech, or the ability to participate in a hearing, is frequently administered to mentally ill persons as treatment or as a means of restraint. During a hearing, the drug-induced side effects can be detrimental to the respondent in two ways. First, they may make the respondent appear to be in far worse condition than he or she actually is. Second, they may prevent or impede the respondent from assisting counsel during the hearing. Accordingly, the guideline recommends that courts adopt a stringent policy that respondents be free of the influences of psychotropic drugs during the hearing. If no alternative treatment will interfere less with the respondent's hearing participation, to reduce the prejudicial effects of the medication to the greatest extent possible, the guideline urges that the factfinder know of the medication and its effect.

Presentation of Evidence/Cross-examination of Witnesses

> GUIDELINE IV-J. (1) EACH PARTY SHOULD BE ENTITLED TO SUBPOENA WITNESSES AND EVIDENCE, AND TO CROSS-EXAMINE ADVERSE WITNESSES.

(2) A COURT SHOULD REQUIRE TESTIMONY FROM AT LEAST ONE PERSON WHO OBSERVED THE RESPONDENT'S CONDUCT PRIOR TO THE FILING OF THE INVOLUNTARY COMMITMENT PETITION, AND FROM AT LEAST ONE PSYCHIATRIST OR CLINICAL PSYCHOLOGIST WHO PERSONALLY EXAMINED THE RESPONDENT AFTER THE FILING OF THE PETITION.

Comment

This guideline contains both a general entitlement provision and specific recommendations regarding the testimony needed to support the allegations in the petition. The first part recommends that all parties to a commitment proceeding (the petitioner, the state, and the respondent) have the right to subpoena witnesses and evidence, and to cross-examine witnesses called by other parties. The rights to present and cross-examine witnesses are at the core of the American judicial process. Because decisions affecting the respondent's liberty may often hinge on subjective interpretations of ambiguous behavior and responses, these rights are particularly important in commitment proceedings. Many current statutes, however, make only vague reference to these rights. Hence, courts should clarify these rights through daily practice and rulemaking.

The second part recommends that the court require testimony from at least one lay witness and one expert witness. Such testimony is necessary to proof of the criteria for commitment (see Chapter Three). The lay witness should be someone who has observed the respondent behave in a manner consistent with the criteria for dangerousness or helplessness. The expert witness should be a psychiatrist or clinical psychologist who has personally examined the respondent and is prepared to offer opinions regarding the presence of mental illness, the respondent's current condition, and what if any types of treatment should be provided. By inference, the guideline discourages having one mental health professional present the testimony at all the hearings held on a particular day, unless he or she personally has conducted the required examination of each respondent. The use of one expert witness who testifies from the notes of the actual examiners may be more efficient from the standpoint of hospital staff management, but this interest is overridden by the court and the respondent's interests in being able to question the examiners personally about their observations and conclusions. Moreover, by instituting proper notice and scheduling procedures, and by holding hearings in the treatment facility, the waiting time and inconvenience of the examiners can be substantially reduced (see Chapter One). Courts may also wish to consider permitting testimony via the telephone or by closed circuit television to accomodate examiners, while protecting the court and respondent's interests.

Evidentiary Matters

GUIDELINE IV-K. (1) INVOLUNTARY COMMITMENT HEARINGS SHOULD BE GOVERNED BY THE RULES OF PROCEDURE AND EVIDENCE APPLICABLE IN CIVIL PROCEEDINGS, UNLESS OTHERWISE SPECIFIED.

(2) THAT A RESPONDENT HAS PREVIOUSLY BEEN INVOLUNTARILY COMMITTED OR THAT THE CONDUCT ALLEGED IN THE PETITION ALSO FORMS THE BASIS OF CRIMINAL CHARGES AGAINST THE RESPONDENT, SHOULD NOT CONSTITUTE EVIDENCE THAT THE RESPONDENT CURRENTLY MEETS THE CRITERIA FOR INVOLUNTARY CIVIL COMMITMENT.

Comment

Although commitment and criminal proceedings have been analogied in these materials, involuntary commitments are civil in nature. Thus, the guideline provides that the usual rules of civil procedure and evidence should govern involuntary civil commitment proceedings, except when special provisions are required to protect the liberty interests involved. Such special provisions include the reduced time limits, the higher standard of proof, and the review procedures recommended elsewhere in the guidelines.

The guideline also indicates that evidence of a respondent's prior commitment, or of the filing of criminal charges against the respondent, should be inadmissible as evidence that the respondent currently meets the criteria for commitment. This does not prevent examining psychiatrists and clinical psychologists from considering the respondent's mental health history in forming their diagnoses and prognoses. Neither does the guideline prevent testimony regarding the behavior underlying the criminal charge. Rather, this guideline is a precaution against the potential prejudicial effects of prior commitment evidence and evidence of pending criminal charges.

Notice of the Right to a Jury

GUIDELINE IV-L. A COURT SHOULD NOT ACCEPT A RESPONDENT'S WAIVER OF THE RIGHT TO A JURY, UNLESS COUNSEL FOR THE RESPONDENT HAS CERTIFIED IN WRITING THAT HE OR SHE HAS DISCUSSED THIS RIGHT WITH THE RESPONDENT, AND REASONABLY BELIEVES THAT THE WAIVER WAS MADE KNOWINGLY AND IS NOT THE RESULT OF THREAT OR COERCION.

Comment

This guideline applies only to jurisdictions that afford respondents the right to a jury at commitment hearings. It requires an affirmative waiver by the respondent. As do other waiver provisions in these guidelines, it directs the attorney for the respondent to explain to the respondent the benefits and detriments of a jury trial, and, if the respondent chooses not to have a jury, to certify that this decision was made knowingly and voluntarily. Counsel should notify the court of the respondent's decision sufficiently ahead of the hearing to permit the necessary scheduling and arrangements. When a commitment hearing is heard by a jury, the court should strongly encourage that the parties present their evidence in the structured format recommended in Chapter Three.

Public Access to Hearings

GUIDELINE IV-M. (1) IN THE ABSENCE OF A STATUTORY PROVISION TO THE CONTRARY, INVOLUNTARY CIVIL COMMITMENT HEARINGS SHOULD BE OPEN TO THE PUBLIC, UNLESS A RESPONDENT'S REQUEST FOR A CLOSED HEARING IS APPROVED. THE COURT SHOULD GRANT SUCH A REQUEST EXCEPT WHEN THE RESPONDENT HAS PLACED HIS OR HER MENTAL HEALTH AT ISSUE IN A RELATED PUBLIC PROCEEDING.

(2) AT THE BEGINNING OF THE HEARING, THE COURT SHOULD INQUIRE WHETHER THE RIGHT TO REQUEST CLOSED PROCEEDINGS HAS BEEN EXPLAINED TO THE RESPONDENT. IF NOT, THE COURT SHOULD DIRECT COUNSEL TO EXPLAIN THIS RIGHT TO THE RESPONDENT. AFTER THE EXPLANATION, IF A REQUEST TO CLOSE THE HEARING IS APPROVED, THE ONLY PERSONS PRESENT SHOULD BE THE JUDGE, NECESSARY COURT PERSONNEL, THE PARTIES, EACH PARTY'S COUNSEL AND FAMILY, AND OTHER PERSONS SPECIFICALLY APPROVED BY THE COURT. THE COURT SHOULD INSTRUCT PERSONS PRESENT TO NOT DIVULGE INFORMATION CONCERNING THE PROCEEDINGS TO EXCLUDED PERSONS.

Comment

Part (1) of the guideline encourages that involuntary civil commitment proceedings be open to the public. As Justice Brennan observed in Nebraska Press Association v. Stuart (427 U.S. 539, 587 (1976) (concurring opinion)):

> Secrecy of judicial action can only breed ignorance and distrust of courts and suspicion concerning the competence and impartiality of judges; free and robust reporting, criticism, and debate can contribute to public understanding of the rule of law and to comprehension of the functioning of the entire ... justice system, as well as improve the quality of that system by subjecting it to the cleansing effects of exposure and accountability.

The guideline would, however, permit a respondent to request a closed hearing to protect his or her privacy, and to reduce the anxiety which might be caused by public disclosure of personal problems. Such requests should ordinarily be granted, except if the respondent has already introduced his or her mental health as an issue in a related public proceeding (e.g., if the respondent has been found not guilty by reason of insanity in a related criminal proceeding). In that situation, the public's strong interest in the proceeding outweighs the respondent's privacy interest.

Like other guidelines concerning a respondent's exercise or waiver of rights, Part (2) of the guideline directs the respondent's attorney to explain to the respondent the available options and their

implications. The guideline calls for the court to ascertain the respondent's choice at the beginning of the hearing. To facilitate scheduling, some jurisdictions may prefer that the court ascertain the respondent's choice prior to the hearing. If the court approves a respondent's request to close the hearing, all persons expect those listed should be directed to leave the courtroom, and those remaining should be instructed to not discuss the evidence and rulings in the case with the public or the press. The phrase "other persons specifically approved by the court" is intended to include, for example, researchers and students studying mental health proceedings. To reduce the possibility that witnesses might consciously or unconsciously alter their stories to conform to prior testimony, witnesses should not be permitted to remain in the hearing room.

In jurisdictions in which involuntary commitment hearings are usually open, courts should discuss with the local news media, the development of voluntary guidelines concerning the proper subject matter for news reporting. Such guidelines should reflect the "fiduciary-like" duty of the press to responsibly exercise its First Amendment rights. In jurisdictions in which these hearings are frequently closed, adequate waiting facilities close to the hearing room should be available for persons excluded from the hearing.

Record of the Hearing

GUIDELINE IV-N. A VERBATIM RECORD SHOULD BE MADE OF ALL INVOLUNTARY COMMITMENT HEARINGS.

Comment

This guideline urges that a stenographic or electronic record be made of all testimony, objections, arguments, instructions, and orders at involuntary commitment hearings. The availability of a record is essential to a respondent's ability to effectuate an appeal.

> Failure to make a record, may be ... to saddle the reviewing process with the burden of attempting to reconstruct a record and to impose upon the ... judge the unseemly duty of testifying under cross-examination as to the events that transpired in the hearings before him. In re Gault, 387 U.S. 1, 58 (1967).

This guideline does not require preparation of an actual transcript of the hearing absent a request by a party.

Expungement of Records Following Dismissal or Denial of the Petition

GUIDELINE IV-O. (1) UPON THE DENIAL OR DISMISSAL OF A PETITION FOR COMMITMENT, ALL COURT RECORDS REGARDING THE COMMITMENT PROCEEDINGS, THAT MIGHT REVEAL THE RESPONDENT'S IDENTITY, SHOULD BE DESTROYED, PROVIDED THAT THE RESPONDENT FILES A FULL RELEASE OF ALL POTENTIAL CLAIMS AGAINST ANY PERSON OR AGENCY ARISING OUT OF THE PROCEEDINGS. IF THE RESPONDENT

DECLINES TO PROVIDE SUCH A RELEASE, THE RECORDS SHOULD BE SEALED. SEALED RECORDS SHOULD BE DISCLOSED ONLY TO THE EXTENT NECESSARY FOR THE DEFENSE OF CLAIMS FILED BY OR ON BEHALF OF THE RESPONDENT.

(2) BEFORE THE RECORDS ARE DESTROYED, A RESPONDENT SHOULD BE PROVIDED WITH A COPY OF THE ORDER DENYING OR DISMISSING THE PETITION, AND SHOULD BE GIVEN AN OPPORTUNITY TO OBTAIN ANY OTHER PORTION OF THE COURT RECORD.

Comment

Although accurate and complete records are needed for the effective operation of the court system, these records "can often outlast their usefulness and may gain unwarranted credibility and importance by reason of their very existence rather than their accuracy and relevance," (American Bar Association Commission on the Mentally Disabled, Guardianship and Conservatorship, 158 (1978)). To lessen the risk to respondents that discrimination and stigma will result from unproven allegations, this guideline recommends expungement of the court records of an involuntary civil commitment proceeding when the petition is dismissed or denied. Destruction of these records will eliminate the possibility that the allegations and information contained in the court file can be misused against the respondent.

To avoid potential problems for the courts, the petitioner, the mental health examiners, the mental health facilities, and the respondents, three conditions restrict the expungement of the records. First, only information from which the respondent's identity can be ascertained must be expunged. This includes any record which is indexed or may be retrieved by name, individual identifying code, address, or other identifying characteristics. Thus, courts could retain aggregate data required for management and analysis purposes (e.g., the number of petitions denied or dismissed, the time required to process those petitions, the grounds for denial).

Second, before the records are destroyed, the respondent would have to sign a release of all potential claims arising from the commitment petition. This is necessary to prevent the respondent from gaining an unfair advantage in subsequent litigation. If the respondent is unwilling to sign such a release, the guideline recommends that public access to the records be limited to the litigants in any suit initiated by the respondent.

Third, a respondent is entitled to a copy of the dismissal or denial order, and to any other portion of the court record. This will enable the respondent to later prove that he or she was not involuntarily committed.

PART V

TREATMENT CONSIDERATIONS DURING JUDICIAL HEARING

Contents

INTRODUCTION

This part of the Provisional Guidelines considers the judicial determination, in a formal hearing, of the treatment and care to be given to a respondent pursuant to involuntary civil commitment. For the sake of exposition and better understanding of the judicial hearing process, the adjudication of the treatment concerns in the formal hearing are considered here separately from the hearing elements relevant primarily to the threshhold question of whether to commit. The latter were considered in Part IV.

Chapter One addresses whether the court should require a treatment plan, when such a plan should be submitted to the court, what a "preliminary" and a "full" treatment plan should contain, and what role the court should play in the modification or implementation of the plan. Chapter Two concerns the court's authority to consider dispositional alternatives to involuntary hospitalization, and to place a respondent meeting the commitment criteria into the least restrictive, sufficient treatment alternative. Finally, Chapter Three considers the respondent's competency to refuse treatment.

CHAPTER ONE

TREATMENT PLAN

THE LAW

Should a Treatment Plan Be Required?

A few states require the preparation of an individualized treatment plan. Of these states, some specify the topics to be addressed in the plan (e.g., Illinois). Others simply call for its preparation (e.g., Indiana, North Carolina, New Mexico).

Preparation of an individual treatment plan can serve several purposes. First, it can help to clarify the treatment goals for the respondent, the treatment staff, and the court. Second, it can provide a vehicle for exploring the various means of achieving these goals, so that the least restrictive alternative can be selected. Third, it can provide an estimate of the period for which the respondent may need treatment. Finally, once approved, the plan defines the services the respondent should expect to receive, how treatment staff will deliver these services, and what obligations the respondent has, and his or her family has. This plan can facilitate judicial review of petitions concerning treatment, and can facilitate the treatment itself.

Treatment plans have drawbacks as well. The time required for staff to prepare a truly individualized plan may diminish the time they can devote to direct contact with patients. More standardized plans are quicker to prepare but are less useful. If either an individualized or "boilerplate" treatment plan is merely filed with the court, but the court fails to examine it, the filing is a totally wasted effort.

On balance, and from the perspective of the trier of fact during a judicial hearing, an individualized treatment plan structured to address the dispositional issues before a commitment court, can significantly assist in determining the appropriate course of treatment, in ensuring that less restrictive alternatives are explored, in clarifying the treatment to be provided, and in facilitating subsequent judicial monitoring and review. The effect of treatment decisions on a respondent justifies the expenditure of time needed to prepare an individualized treatment plan. The guidelines in Chapter Two will help to ensure that the effort is not wasted.

Timing

Of the states requiring treatment personnel to submit an individualized treatment plan to the court, most indicate that preparation of the full plan should follow the commitment hearing (e.g., Indiana, Michigan, New Mexico). A few states, however, specify that a preliminary or proposed plan be submitted in time for the court to consider it at the hearing (e.g., Illinois, North Carolina).

Although it would be highly desirable to have a full treatment plan available at the dispositional phase of the commitment hearing, it is probably unrealistic to expect that treatment teams could prepare one for each respondent in the brief period between the submission of an application or petition, and the hearing (see Part IV, Chapter One). This leaves two alternatives, given the court's need for some guidance in framing a dispositional order. The first is the Illinois procedure, requiring that prior to hearing, the individual responsible for coordinating treatment submit information on alternative settings, submit results of a social investigation of the respondent, and submit a preliminary treatment plan; a full plan must then be filed within 30 days after the hearing. In Chicago, Institute project staff observed that the preliminary plans tended to be brief and general, but that even these reports forced hospital staff to confront treatment choice and feasibility for each respondent. Further, preliminary plans helped to educate lawyers and judges about the types of treatment available in the hospitals, the time periods in which treatments might be effective, and the nature of "cures" that could be expected from these treatment modalities. The second option is to delay the dispositional portion of the commitment process, at the respondent's request, to permit preparation of the plan. This would be appropriate primarily in non-emergency cases in which immediate and continuous treatment are unnecessary.

If certain safeguards are present, the first option should permit the court to make an informed decision without unduly burdening or delaying the process. These safeguards include permitting the respondent to obtain an independent examiner, at state expense if necessary (see, Part II, Chapter Four); requiring that the preliminary plan be truly individualized; providing the respondent with an opportunity to participate in the preparation of, and to challenge, both the preliminary and full treatment plans; authorizing the court to require submission of the full treatment plan and a hearing on that plan; and requiring court approval for the treatment plan.

GUIDELINES

Preliminary Treatment Plan

GUIDELINE V-A. (1) THE HOSPITAL DIRECTOR, OR HIS OR HER DESIGNEE, SHOULD SUBMIT A PRELIMINARY TREATMENT PLAN TO THE COURT, TOGETHER WITH THE MENTAL HEALTH EXAMINER'S REPORT. THE COURT SHOULD PROVIDE A COPY TO ALL PARTIES.

(2) THE PRELIMINARY PLAN SHOULD BE PREPARED BY THE EXAMINING PSYCHIATRIST(S), CLINICAL PSYCHOLOGIST(S), OR OTHER MEMBERS OF THE TREATMENT TEAM, AND SHOULD SPECIFY (a) THE PROPOSED TREATMENT GOALS, (b) THE SERVICES AND TREATMENT METHODS AVAILABLE TO ASSIST IN MEETING THOSE GOALS, (c) WHICH OF THESE SERVICES AND TREATMENT METHODS ARE MOST LIKELY TO ASSIST THE RESPONDENT, (d) THE PROPOSED TREATMENT SETTING AND

REASONABLE ALTERNATIVES THERETO, AND (e) AN ESTIMATE OF THE TIME REQUIRED TO ACHIEVE THE TREATMENT GOALS. THIS PLAN SHOULD BE TAILORED TO THE RESPONDENT'S NEEDS. EXCEPT IN THE DESCRIPTION OF AVAILABLE SERVICES, STANDARDIZED PROVISIONS SHOULD NOT BE USED.

(3) TO THE MAXIMUM EXTENT POSSIBLE, THE RESPONDENT SHOULD BE INVOLVED IN THE PREPARATION OF HIS OR HER PRELIMINARY TREATMENT PLAN.

Comment

This guideline requires preparation and filing of a preliminary treatment plan prior to the commitment hearing. This plan should be submitted to the court with the mental health examination reports (see Guideline II-Y, paragraph (2), in Part II, Chapter Four). The plan should provide the court with the information necessary to make an informed decision. In addition, it should clarify for the court, the respondent, and the service providers, what the preliminary treatment objectives are, how these objectives will be achieved, and how long treatment may take. Because only a brief time is available for preparing the plan, the preliminary plan should contain only the most essential information. More detailed information regarding the treatment goals, proposed services, and proposed setting (e.g., public hospital, private facility, community mental health center), and the basis for the recommendations, may be presented at the dispositional portion of the commitment hearing. Except for the description of the available services, however, the guideline expressly prohibits the use of boilerplate language. This prohibition emphasizes that a truly individualized plan is required and that standardized language should not be accepted.

Finally, the guideline encourages the respondent's involvement in preparation of the plan. An involuntary civil commitment proceeding is not the most conclusive time for cooperation between service providers and patients. Nevertheless, it is critical that the respondent participate in treatment decisions. To facilitate this participation, the individuals preparing the plan should explain to the respondent, in the language, mode of communication, and terms, that the respondent is most likely to understand, the different treatment methods and services under consideration.

Full Treatment Plan

GUIDELINE V-B. (1) NO MORE THAN 30 DAYS AFTER THE RESPONDENT HAS BEEN FOUND TO MEET THE CRITERIA FOR INVOLUNTARY CIVIL COMMITMENT, OR WITHIN SUCH SHORTER PERIOD AS THE COURT MAY PRESCRIBE, THE AGENCY OR INDIVIDUAL RESPONSIBLE FOR PROVIDING OR COORDINATING SERVICES AND TREATMENT FOR THE RESPONDENT, SHOULD SUBMIT A FULL TREATMENT PLAN TO THE COURT. THE COURT SHOULD PROVIDE A COPY OF THE PLAN TO ALL PARTIES AND TO RESPONDENT'S COUNSEL.

(2) THE FULL TREATMENT PLAN SHOULD BE TAILORED TO THE RESPONDENT'S NEEDS. STANDARDIZED PROVISIONS SHOULD NOT BE USED. THE PLAN SHOULD INCLUDE (a) A DETAILED EVALUATION OF THE RESPONDENT'S STRENGTHS, PROBLEMS, AND NEEDS, (b) A DESCRIPTION OF THE SERVICES AND TREATMENT ADMINISTERED TO THE RESPONDENT AFTER HE OR SHE WAS TAKEN INTO CUSTODY AND DETAINED PURSUANT TO INVOLUNTARY COMMITMENT, (c) A DESCRIPTION OF THE SERVICES AND TREATMENT PROPOSED, AND OF HOW THESE WILL ASSIST THE RESPONDENT IN MEETING TREATMENT OBJECTIVES, TOGETHER WITH POSSIBLE SIDE EFFECTS, AND AVAILABLE ALTERNATIVES, (d) THE AGENCIES AND INDIVIDUALS WHO WILL PROVIDE THE SERVICES AND TREATMENT, (e) THE SETTING IN WHICH THE SERVICES AND TREATMENT WILL BE PROVIDED, (f) AN EXPLANATION OF HOW PROGRESS TOWARD THE GOALS WILL BE MEASURED AND OF THE PROJECTED TIMETABLE FOR ATTAINING THE GOALS, (g) A STATEMENT OF CRITERIA FOR TRANSITION TO LESS RESTRICTIVE SERVICES, TREATMENT, OR PLACEMENTS, AND FOR DISCHARGE FROM SERVICES AND TREATMENT, AS WELL AS THE PROJECTED DATE FOR TRANSITION OR DISCHARGE, AND (h) THE SIGNATURES OF THE PREPARERS, AND THE DATE.

(3) TO THE MAXIMUM EXTENT POSSIBLE, THE RESPONDENT SHOULD BE INVOLVED IN THE PREPARATION OF HIS OR HER TREATMENT PLAN.

Comment

This guideline calls for the submission of a complete treatment plan following commitment. The plan is designed to inform all concerned of what services and treatment will be provided, how and where they will be delivered, by whom, for how long, and why. The full treatment plan should assist the court when it is called upon to make postcommitment decisions (see Part VI, Chapter One). The mental health facility or individual responsible for the respondent's care and treatment should prepare the plan. As in the preliminary treatment plan, boilerplate provisions are mimical to achieving truly individualized treatment, and should not be accepted. The proposed format of the full treatment plan is based on that contained in the chapter entitled "Right and Admission to Services" in Sales, Powell, Van Duizend & Associates, Disabled Persons and the Law: State Legislative Issues, (Plenum, 1982). Finally, the guideline recommends that the respondent should participate in the development of the plan, both as a procedural safeguard and to enhance treatment.

Review of Treatment Plans

GUIDELINE V-C. (1) THE PARTIES SHOULD BE ENTITLED TO PRESENT EVIDENCE AND ARGUMENT REGARDING THE PRELIMINARY TREATMENT PLAN DURING THE DISPOSITIONAL PHASE OF THE COMMITMENT HEARING. THE COURT SHOULD HAVE THE AUTHORITY TO APPROVE OR MODIFY THE

PRELIMINARY TREATMENT PLAN, OR ORDER THAT THE SUBMISSION OF A FULL TREATMENT PLAN BE EXPEDITED.

(2) WITHIN FIVE DAYS AFTER SUBMISSION OF THE FULL TREATMENT PLAN, ANY PARTY SHOULD BE ENTITLED TO REQUEST A PROMPT HEARING TO REVIEW THE PLAN. THE REQUEST SHOULD INDICATE THE PARTS OF THE PLAN TO BE CHALLENGED. AT THE HEARING, THE COURT SHOULD BE ENTITLED TO APPROVE, MODIFY, OR ORDER REVISION OF, THE FULL TREATMENT PLAN.

Comment

Without the opportunity for review and the possibility of challenge, preparation of a treatment plan can easily become a meaningless ritual, rather than an effective technique for ensuring that respondents are provided with appropriate services. Accordingly, Guideline II-C urges that the parties be entitled to present evidence supporting or questioning both the preliminary and full treatment plans, and that the court accept the responsibility for approving, modifying, or ordering the revision of the plan. The intent of the guideline is not to substitute legal for medical expertise in making treatment decisions. Rather, it is to provide a forum for resolving disputes, protecting rights, and ensuring that responsibilities consequent to the commitment decision are being met. The court's attention ordinarily will be focused upon the restrictiveness of the proposed setting and the appropriateness of particularly intrusive forms of treatment. The provision for court approval does not imply that any change in the services, treatment, and setting, prescribed in the plan requires prior judicial authorization. If a party petitions for judicial review (see Part VI, Chapter One) of a treatment decision, however, the court should have the authority to modify or expedite implementation of the treatment plan.

CHAPTER TWO

DISPOSITIONAL DECISION

THE LAW

Consideration of Alternatives

Many current statutes authorize the court to consider alternatives to committing an individual to a public mental health hospital. These alternatives include placement in a private hospital (e.g., Illinois, Michigan, New York, North Carolina, Ohio), in a community, non-residential treatment program (e.g., Illinois, North Carolina, Ohio, Virginia, West Virginia), or with a relative or friend (e.g., Illinois, New York, West Virginia). Other states (e.g., Oklahoma) authorize the court to order "whatever placement other than hospitalization is appropriate."

The authority to consider dispositional alternatives provides the court the flexibility needed to fashion the dispositional order best able to ensure that a respondent found to meet the commitment criteria will receive the treatment he or she requires. This authority is essential to application of the "least restrictive alternative" principle. Although involuntary civil commitment has in the past been synonymous with inpatient hospitalization, it need not so remain (see Part IV, Chapter Three).

Use of the Least Restrictive Alternative

In recent years, the principle of using the least restrictive alternative has enjoyed increasing support and recognition in both statutory and case law. The principle holds that "when the government ... [has] a legitimate communal interest to serve by regulating human conduct it should use methods that curtail human freedom to no greater extent than is essential for securing that interest," (Chambers, "The Principle of the Least Restrictive Alternative: The Constitutional Issues," in President's Commission on Mental Retardation, The Mentally Retarded and the Law, 486 (1976)).

Several states have incorporated this principle into their involuntary commitment statute. As might be expected, these provisions are phrased in different ways. Some states simply require the court to order the least restrictive alternative (e.g., Illinois, Ohio). Others specify that hospitalization be ordered only if the court finds no available appropriate alternative (e.g., Arizona, Massachusetts, Virginia, Washington). A third variation directs courts to give "thorough consideration" to available alternatives (e.g., Michigan, Oklahoma).

An argument frequently asserted against application of the least restrictive alternative principle to involuntary commitment proceedings is that a respondent's participation and cooperation in ordered treatment

cannot be ensured; within a short time, a new petition may have to be filed and the process begun anew. The success of adequately funded outpatient services suggests that more people can be treated in the community than have been in practice. The respondent's willingness to comply with outpatient treatment, however, is a major factor in determining whether non-institutional treatment is appropriate.

Use of the least restrictive alternative has advantages to all people concerned. For the service provider, it offers a greater opportunity for working with willing patients, rather than with patients in a setting that minimizes the opportunity for the patient to make decisions. For the public, it limits the expense of constructing and operating institutional facilities. For the respondent, it obviously reduces the restraints placed on liberty, while providing the opportunity for treatment. Thus, courts are urged to incorporate the use of the least restrictive alternative into the process for making dispositional decisions in commitment cases.

GUIDELINES

Timing

GUIDELINE V-D. THE COURT SHOULD MINIMIZE PRESENTATION OF EVIDENCE AND ARGUMENT REGARDING THE APPROPRIATE DISPOSITION UNTIL AFTER A FINDING THAT THE RESPONDENT MEETS THE COMMITMENT CRITERIA.

Comment

In keeping with Guideline IV-H, paragraph (1) (in Part IV, Chapter Three), requiring a more ordered presentation of evidence in involuntary commitment proceedings, Guideline V-D urges that the court not consider dispositional questions until after it determines that the respondent is eligible for commitment. The mixing of eligibility and dispositional evidence is often a source of confusion. It creates the possibility that a respondent may be committed because he or she needs services, even though he or she does not meet the other criteria for involuntary commitment.

Nothing in this guideline prevents initiation of the dispositional portion of the proceeding immediately upon the determination of eligibility. Because many of the witnesses who testified regarding the respondent's mental condition are likely to testify regarding treatment as well, considering the dispositional issues at once has definite efficiency and convenience advantages. Some jurisdictions, however, may prefer to delay the dispositional hearing until a full treatment plan can be prepared. This would give the court the benefit of a more thorough assessment of the respondent's needs and of the available alternatives.

File of Alternative Dispositions

GUIDELINE V-E. THE COURT SHOULD PREPARE AND MAINTAIN A FILE OF ALL MENTAL HEALTH TREATMENT PROGRAMS AND FACILITIES WITHIN ITS JURISDICTION, INCLUDING THE SERVICES OFFERED, THE ELIGIBILITY REQUIREMENTS IMPOSED, AND THE COSTS INVOLVED.

Comment

As the focal point of the involuntary commitment process, the court is in the best position to maintain a comprehensive catalogue of mental health services available from both the public and private sectors. This file can be of enormous value to screeners, petitioners, respondents, attorneys, and examiners, as well as to judges who hear commitment proceedings. In forming the file and keeping it current, the court should seek the assistance of state and local mental health agencies, community mental health associations, and advocacy groups.

Use of the Least Restrictive Alternative

GUIDELINE V-F. AFTER REVIEWING THE TREATMENT PLAN, AND CONSIDERING THE EVIDENCE AND ARGUMENTS PRESENTED, THE COURT SHOULD IMPOSE THE LEAST RESTRICTIVE DISPOSITIONAL ALTERNATIVE THAT WILL ACHIEVE APPROPRIATE TREATMENT GOALS.

Comment

As indicated above, involuntary civil commitment is no longer synonymous with placement of a respondent in the maximum security ward of a state mental hospital. Techniques and settings available for assisting mentally ill individuals are increasing in number. Because of the availability of placement alternatives, because of the constitutional mandate that the nature and duration of a commitment must bear a reasonable relationship to the purpose of the commitment (Jackson v. Indiana, 406 U.S. 715 (1972); O'Connor v. Donaldson, 422 U.S. 563 (1975)), and because a state may not impose any greater restrictions on fundamental freedoms than is necessary to serve a legitimate state interest (e.g., Shelton v. Tucker, 364 U.S. 479 (1960); Lake v. Cameron, 364 F.2d 657 (1966)), legislatures and courts have increasingly recognized the principle of the least restrictive alternative.

This guideline is in accordance with that trend. It calls upon the court to select the least drastic means available for achieving the treatment objectives. This does not mean that the judge must decide the appropriate dosages of the drugs to be administered, or the intensity of therapy. Rather, it requires the court to consider the types of settings (e.g., maximum security ward, non-secure ward, outpatient community mental health care), and the broad classes of therapy and services proposed, and to select the one(s) which best addresses the respondent's needs and problems, and which intrudes least upon the respondent's

freedom of action and bodily integrity (see e.g., Chambers, Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives, 70 Michigan Law Review, 1107 (1972); Shapiro, Legislating the Control of Behavior Control: Autonomy and Coercive Use of Organic Therapies, 47 Southern California Law Review, 237 (1974)).

Form of the Order

> GUIDELINE V-G. (1) THE ORDER INVOLUNTARILY COMMITTING AN INDIVIDUAL SHOULD SET FORTH CLEARLY (a) THE GROUNDS UPON WHICH THE COMMITMENT IS BASED, (b) THE TYPES OF SERVICES AND TREATMENT TO BE PROVIDED, (c) WHETHER THE SERVICES AND TREATMENT ARE TO BE PROVIDED ON AN INPATIENT OR OUTPATIENT BASIS, (d) WHETHER THE PRELIMINARY TREATMENT HAS BEEN APPROVED, REJECTED, OR MODIFIED, AND (e) THE DATE ON WHICH THE FULL TREATMENT PLAN IS DUE.
>
> (2) THE COURT SHOULD DIRECT COUNSEL FOR THE RESPONDENT TO EXPLAIN TO THE RESPONDENT THE TERMS OF THE ORDER.

Comment

Guideline V-G seeks to clarify the outcome of the commitment proceeding for the respondent, petitioner, and service provider. It calls for the court to specify which criteria for involuntary commitment have been met, what types of services and treatment are to be provided, who is responsible for providing them, and whether the respondent will be hospitalized, or helped in the community. So that the respondent may be aware of what has occurred and what is to come, the guideline requires that counsel explain the commitment order to the respondent.

CHAPTER THREE

RESPONDENT'S CAPACITY TO REFUSE TREATMENT

If a respondent is found eligible for involuntary civil commitment, a question may arise concerning the respondent's competence to decline all or specific types of treatment. Related questions concern how to determine whether the respondent is competent to make the treatment decision, and who should decide whether the respondent is competent. Some states include incompetency to make treatment decisions as one of the criteria for commitment (e.g., New York), or include a competency determination as part of the commitment proceeding (e.g., Idaho, Oklahoma). Others specify that the court should not presume a person to be incompetent simply because he or she is found to meet the criteria for involuntary commitment (e.g., Illinois, New Mexico). Some states make the determination of competency in a separate proceeding (e.g., West Virginia). Many current commitment statutes do not address these issues at all.

The right of a patient to refuse treatment is the subject of increasing litigation and controversy; particulary when the patient is mentally ill. The absence of consent, due to physical incapacity or psychosis, can frustrate the purpose of the commitment procedure. On the other hand, labeling every objection to a proposed form of treatment as a manifestation of the respondent's mental illness can lead to serious infringements of an individual's rights, particularly when the treatment has harmful side effects. Thus, procedures are needed for assessing whether the respondent is able to achieve rudimentary understanding of the purpose, nature, significant benefits, and possible harmful effects, of the proposed treatment.

Because mental health experts, court personnel, and attorneys are present, having the determination of competency as a routine part of the commitment hearing has obvious efficiency advantages. Routinization, however, may make it easy to slip into a working, though unarticulated presumption that all persons eligible for commitment are incompetent. Particularly in states which do not have provisions for limited guardianships and for periodic judicial review of the need for continuing a guardianship, this presumption may lead to total suspension of a person's power to conduct his or her own affairs for substantially longer than the involuntary treatment period.

The manner in which questions regarding the respondent's competence to refuse treatment are handled, largely depends on a state's guardianship law and, thus, lies beyond the scope of this volume. Under a limited guardianship, the authority of the surrogate decisionmaker can be limited to treatment issues, if the respondent is able to manage personal affairs. In any case, at a minimum, care should be taken to assure that the respondent's rights are protected and that the scope and duration of the guardianship are no greater than are necessary.

PART VI

POSTHEARING MATTERS

Contents

INTRODUCTION

This part of the Provisional Guidelines concerns issues arising after a judicial hearing has taken place and a respondent has been ordered to undergo involuntary treatment or care. Chapter One considers the different avenues for review of a respondent's confinement, including appeal of the commitment order, writ of habeas corpus, and periodic judicial reviews of the respondent's continuing need for compulsory treatment or care. Chapter Two considers the difficult question of the court's proper role in the programs and arrangements of mental health facilities that hold involuntarily committed persons.

The brevity of this part of the Provisional Guidelines, as compared to Part II, "Prehearing Matters," suggests this part's message to judges, court administrators, and managers, regarding posthearing matters: except for relatively minor administrative matters, and periodic reviews of the respondent's status, the commitment court's work should be complete after issuance of the commitment order. The commitment court's restraint in posthearing matters, however, should be balanced by activism in prehearing matters. The few guidelines set forth in this part are consistent with this message.

If the court has actively pursued its prehearing responsibilities in a manner consistent with the guidelines and general themes in Part II, many of the duties traditionally viewed as the responsibility of the commitment court will have already been more fairly and expeditiously discharged than if they were handled only after the commitment order. For example, notifying appropriate individuals of a respondent's involuntary hospitalization is treated in many states (e.g., Virginia, New Jersey) as a posthearing matter. If these individuals were properly notified when the respondent was first taken to a mental health facility, however, no need would remain for posthearing notification. Prehearing notice better serves concerned parties' interests in that after initial hospitalization, a respondent may be involuntarily detained for days, or even weeks, until the court's commitment decision. If courts require adequate notice upon a respondent's admission to a mental health facility, only the notification of discharge, or the court's adjudication of continued commitment upon judicial review or periodic hearings, need be a concern after the initial commitment.

This message calling for judicial restraint in posthearing matters is consistent with current practice (albeit not always coupled with activism in prehearing matters) in the jurisdictions in which the Institute conducted its field work. For the most part, the courts' involvement in particular cases with mental health facilities ended with the commitment order. For example, appeals and periodic review hearings are relatively infrequent in Columbus, Ohio. Eight out of ten respondents initially hospitalized by court order are subsequently discharged from the hospital, or elect to become voluntary patients, even before an initial full hearing takes place. One additional respondent in this group of ten is diverted from compulsory hospitalization by the same mechanisms before a review hearing can take place. Thus, in Columbus,

only one out of ten persons whose involuntary civil commitment has been sought by means of a formal action remains involuntarily hospitalized for the initial commitment period of 90 days. As infrequent as periodic review hearings are in Columbus, they constitute, for all practical purposes, the total involvement of the commitment court with respondents following the initial full hearing (see Columbus, p. 91). Challenges to various aspects of confinement, violations of patients' rights, and objections to institutional practices are generally left to independent advocacy agencies (e.g., the Ohio Legal Rights Service and New York's Mental Health Information Service), administrative reviews, and to the discretion of mental health professionals.

The trend in recent federal court decisions is clearly consistent with this message of judicial restraint in posthearing matters. Speaking for the majority of the Supreme Court, Justice Powell stated in Youngberg v. Romeo, 50 U.S.L.W. 476, 4685 (1982):

> ... [D]ecisions made by the appropriate [mental health] professional are entitled to a presumption of correctness. Such a presumption is necessary to enable institutions of this type--often, unfortunately, overcrowded and understaffed--to continue to function. A single professional may have to make decisions with respect to a number of residents with widely varying needs and problems in the course of a normal day. The administrators, and particularly professional personnel, should not be required to make each decision in the shadow of an action for damages.

By expressing a presumption of correctness, the court recognized a very limited judicial review of professional decisions regarding conditions of confinement for an involuntarily committed person.

CHAPTER ONE

REVIEW OF RESPONDENT'S STATUS AFTER INVOLUNTARY COMMITMENT

Checks on the validity or appropriateness of a respondent's continued involuntary commitment may be achieved by administrative review or by judicial review. Review may be mandatory or upon request of either the respondent or someone on his or her behalf, or upon request of an individual or agency seeking the respondent's confinement. As indicated earlier, as a practical matter, only periodic judicial review hearings involve much of commitment court's time and effort.

THE LAW

Appeal, Writ of Habeas Corpus, and Other Remedies

Most states recognize a right of appeal in involuntary civil commitment cases. Provisions for appeal may be included specifically in a state's mental health code. Alternatively, the mental health code may state that an appeal may be taken in the same manner as in other civil cases (e.g., Illinois, Massachusetts). The right to appeal is not specifically addressed in the mental health code of at least two states (e.g., New Jersey, Ohio). The Ohio statute, however, implies such a right by requiring that a transcript and record be made of the commitment proceedings.

When specifically included in a mental health code, appeal provisions may delineate various considerations: who may appeal; what judicial body receives the appeal; what specific procedures initiate appeal; whether the appeal is on the record or de novo; if the appeal is de novo, whether there is a right to a jury; the specific timing of appeal; and, finally, provisions for release of the respondent pending appeal of his or her commitment.

Most states recognize the right to petition for a writ of habeas corpus challenging a civil commitment. A writ of habeas corpus is a collateral attack on a previous judgment and is an extraordinary legal process typically only used when other remedies have proven unsuccessful. A writ of habeas corpus may be filed in a superior court, probate court, state appellate court, state supreme court, or in a federal court if state remedies have been exhausted.

Petitions for a writ of habeas corpus are rare, except in California where several of the commitment routes have no recourse to a judicial hearing except by writ of habeas corpus. Upon receiving a petition for writ of habeas corpus, California courts must either release a respondent or order an evidentiary hearing to be held within two judicial days after a petition is filed. Writ of habeas corpus hearings are available upon request to respondents "certified" for fourteen days of involuntary intensive treatment following an initial 72-hour detention for emergency evaluation and treatment; to respondents posing an imminent suicide threat "recertified" for an additional fourteen days of

treatment; and, to respondents for whom a temporary conversatorship has been created (see Los Angeles, p. VII-1).

As indicated in Part II, Chapter Five, "Diversion and Release Before Judicial Hearing," some states provide formal and informal administrative remedies for contesting involuntary civil commitment. Mental health personnel may notice a remission of symptoms in the respondent and, on their own initiative, effect discharge. Alternatively, the patient him or herself may convince mental health personnel of symptom remission and, thereby, justify and effect discharge. Finally, respondents may within certain restrictions, request a conversion from involuntary to voluntary status.

Periodic Review Hearings

Most states require that protracted periods of involuntary commitment be accompanied by periodic reviews to determine whether such commitment is necessary and appropriate. Such reviews may be conducted by a judicial body or by the mental health facility administration. Administrative periodic reviews of all patients, regardless of their status, are required in most states. In Massachusetts, for example, such reviews must occur at least once upon admission, once during the first three months of commitment, once during the second three months of commitment, and annually thereafter. Such reviews must include a clinical examination, a review of the patient's legal competency, and a consideration of alternative care and treatment.

State statutes generally provide judicial review procedures to extend commitment beyond the initial period authorized by commitment order. Periodic review hearings are mandatory (e.g., Idaho, Ohio) or provided upon request of the respondent (e.g., Indiana). In Ohio, for example, a respondent has a right to mandatory periodic review of the initial commitment decision. Review must occur at the end of the first 90 days after the original commitment decision. Thereafter, review hearings must be held at least every two years, except that upon request a respondent is entitled to a hearing every 180 days. At least ten days before the end of the initial 90-day commitment, the applicant who sought the respondent's commitment, or the head of the hospital, must file with the court another application for continued commitment.

For the most part, the recommitment procedure is essentially the same as for the initial commitment. The burden of proof remains with the committing facility. The respondent retains the right to counsel, to present independent testimony, and to proper notice.

GUIDELINES

Beyond periodic judicial reviews, the use of legal remedies against protracted involuntary commitment is rare; it is even rarer for these actions to come to the direct attention of the commitment court. Some judges interviewed during the Institute field work had difficulty recalling any appeals from their commitment orders.

The infrequency of appeals is not surprising. Appellate review is an extremely time-consuming process. Most respondents are released from involuntary hospitalization long before an appellate hearing could take place. In the opinions of legal and mental health practitioners, respondents that face protracted involuntary commitment are typically individuals in the most desperate need for inpatient treatment and care. Also, if the respondent's case does not present legal reform issues, and the respondent is discharged prior to the appellate hearing, the case may be dismissed for mootness. A factor that may account for the infrequency of appeals in some jurisdictions (e.g., Columbus, Ohio) is the procedure of dismissing the respondent's counsel upon completion of the judicial hearing. Consequently, many attorneys are unfamiliar with the appeals process. Another factor that may account for the infrequency of appeals is that few cases represent problems or issues that warrant this remedy.

GUIDELINE VI-A. COURTS SHOULD ENCOURAGE DEVELOPMENT OF TRAINING PROGRAMS FOR RESPONDENT'S ATTORNEYS CONCERNING THE USE OF APPEALS, PETITIONS FOR WRIT OF HABEAS CORPUS, AND OTHER LEGAL OPTIONS FOR CONTESTING INVOLUNTARY CIVIL COMMITMENT.

Comment

From the standpoint of economy and efficiency, appellate review and petitions for writ of habeas corpus may be much less attractive and workable options for the respondent's release than are other administrative remedies. Perhaps the most common workable option is for the respondent to apply for voluntary hospitalization. In Ohio, for example, the opportunity for voluntary admission is available to a respondent at any time, regardless of the length of time the respondent has already been involuntarily hospitalized. The hospital must either discharge the respondent after his or her request for voluntary admission or file an affidavit with the court to hold the respondent in the hospital. Appellate review and other remedies are important, however, for protection of involuntarily committed persons' liberty interests. Appellate review allows not only review of particular cases, but perhaps more importantly it allows the settling of points of law interpreted differently by various commitment courts within a jurisdiction. In a field as unclear as mental health law, it may be advisable to encourage development of case law clarifying ambiguous statutory provisions. In jurisdictions where appeals have been discouraged, and where expedited appeals are not the common practice, statutory ambiguity and confusion have persisted. If clarification has been sought at all, it has been sought through repeated trips to the legislature, a wasteful and exhausting process to most concerned. Guideline VI-A seeks to ensure that appellate review and other remedies remain available as options and do not become unavailable due to their unfamiliarity.

GUIDELINE VI-B. (1) A WRITTEN REPORT DETAILING THE NATURE AND RESULTS OF TREATMENT AND CARE SINCE THE LAST JUDICIAL REVIEW SHOULD BE FILED WITH THE COURT AND MADE AVAILABLE TO THE RESPONDENT'S COUNSEL AT LEAST THREE DAYS BEFORE A REVIEW HEARING.

(2) RESPONDENT'S COUNSEL SHOULD BE ENCOURAGED TO SUBPOENA MEMBERS OF THE RESPONDENT'S TREATMENT TEAM TO TESTIFY AT REVIEW HEARINGS.

Comment

The record of the respondent's care and treatment during the most recent commitment period is crucial information in judicial review hearings. The report required by part (1) of the guideline should include the information detailed in Guideline V-B, insofar as relevant. At issue is not only the commitment per se, but the treatment and care provided the respondent, and the extent to which he or she is benefiting from them. At the initial hearing, the court's deliberations of treatment and placement of the respondent into the most appropriate treatment setting are largely a matter of conjecture, given the brief time the respondent may have been confined and the limited factual information the court can draw upon. Given sixty days (in most states) of treatment history, however, the court has the opportunity to test the validity and appropriateness of continued commitment based upon specific facts of treatment. These facts should be clearly before the court.

CHAPTER TWO

INSTITUTIONAL PROGRAMS, PRACTICES, PATIENTS' RIGHTS AND THE ROLE OF THE COMMITMENT COURT

How much, if at all, should the commitment court be concerned with the effects of the commitment order on the respondent once he or she is in the mental health facility (e.g., the respondent's functioning in the hospital; the respondent's participation in, and benefit derived from, the prescribed treatment and care; and the respondent's demands about his or her treatment)? Should the commitment court take an active role in the institutional life of the involuntarily committed individual to balance the individual's liberty and treatment interests and the public's interest? The answer to these questions provided by the guidelines in this brief chapter is consistent with the message conveyed in the introduction to this part of the Provisional Guidelines. Namely, judges and other commitment court personnel, beyond their responsibilities to the cases coming before them during judicial commitment review hearings, have only a small and indirect role to play in institutional programs and practices.

> GUIDELINE VI-C. (1) A COMMITMENT COURT'S DIRECT INTERVENTION IN THE POST-COMMITMENT PROGRAMS AND PRACTICES OF MENTAL HEALTH FACILITIES SHOULD BE LIMITED TO THOSE ACTIVITIES DIRECTLY RELATED TO TREATMENT CONSIDERATIONS DURING JUDICIAL HEARINGS IN ACCORDANCE WITH GUIDELINES IN PART V.
>
> (2) JUDGES AND OTHER COMMITMENT COURT PERSONNEL, HOWEVER, SHOULD ASSIST OTHER UNITS OF THE MENTAL HEALTH-JUDICIAL SYSTEM (E.G., COMMUNITY MENTAL HEALTH CENTERS, INPATIENT HOSPITALS, PATIENT ADVOCACY GROUPS) IN COOPERATIVE STRATEGIES TO PROMOTE IMPROVEMENT OF SERVICES TO INVOLUNTARILY COMMITTED PERSONS, AND TO PROMOTE THEIR RIGHTS.

Comment

Together with the guidelines in Part II, "Prehearing Matters," which urged a greater emphasis on issues arising before formal judicial review, Guideline VI-C calls for achieving linkages, coordination, and cooperation among the units of the complex interorganizational network comprising the mental health-judicial system. Importantly, Guideline VI-C urges a clear delineation of the role that the commitment court should play in the programs and practices of mental health facilities.

Guideline VI-C is not a suggestion that all is well in the delivery of mental health care and treatment provided to involuntary patients, nor should it be construed as a call for judges and court personnel to abrogate all concern for institutional practices. Instead, in recognition that promotion of rights and improvement of mental health services administration is an immense job, it urges a division of labor,

and proposes that the commitment court limit its direct intervention to judicial review hearings. Further, in recognition that other parts of the system (e.g., advocacy groups, mental health centers, appellate courts) must work together to improve programs and practices, Guideline VI-C urges the development of cooperative strategies.

A very good example of such cooperation is the interdisciplinary proposal adopted in implementing the decision in Davis v. Hubbard, 506 F. Supp. 915 (N.D. Ohio 1980). The proposal was written over a period of two years by an interdisciplinary group including legal and mental health practitioners, was circulated for comments to the various units of the mental health-judicial system in Ohio, was adopted by both the state and the plaintiffs in the Davis v. Hubbard case, and is being considered for possible adoption in Ohio's state hospitals (see Hickman, Resnick, and Olson. Right to Refuse Psychotropic Medication: An Interdisciplinary Proposal, Mental Disability Law Reporter, 6(2), p. 122-130 (1982)).

PART VII

SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS FOR IMPROVEMENT OF INVOLUNTARY CIVIL COMMITMENT IN FIVE METROPOLITAN AREAS IN THE UNITED STATES

Contents

INTRODUCTION

The foregoing parts of the Provisional Guidelines are based, in large part, upon extensive study of the involuntary civil commitment processes throughout the country. This final part is a summary of conclusions about and recommendations for improvements of the involuntary civil commitment systems in five metropolitan areas in the United States: Chicago, Columbus (Ohio), Winston-Salem (North Carolina), Los Angeles, and New York City. Each chapter is an excerpt from one of the five Institute reports listed below.

J. Zimmerman. Involuntary Civil Commitment in Chicago, January 1982.

I. Keilitz. Involuntary Civil Commitment in Columbus, Ohio, April 1982.

W. L. Fitch. Involuntary Civil Commitment in Winston-Salem, February 1982.

I. Keilitz, W.L. Fitch, and B. McGraw. Involuntary Civil Commitment in Los Angeles County, May 1982 (Revised August 1982).

W.L. Fitch, J. Hendryx, T.B. Marvell, and B. McGraw. Involuntary Civil Commitment in the First Judicial District, New York City, June 1982 (Revised October 1982).

It should be noted that the chapters in this part of the Provisional Guidelines are broad conclusions and recommendations with little commentary. The reader is strongly encouraged to refer to the full reports from which the conclusions and recommendations have been excerpted. Out of context, and without supporting commentary the conclusions and recommendations may appear to be what they are not. Full reports are available from the Institute on Mental Disability and the Law.

CHAPTER ONE

CHICAGO, ILLINOIS: RECOMMENDATIONS

Voluntary Admissions

RECOMMENDATION: THE COURT SHOULD MEET WITH STATE HOSPITAL ADMINISTRATORS TO REVIEW THEIR REASONS FOR THEIR USE OF VOLUNTARY RATHER THAN INFORMAL ADMISSIONS; THE COURT SHOULD NOT INTERFERE WITH THIS PRACTICE UNLESS IT CLEARLY CAN BE SHOWN NOT TO BE IN THE BEST INTERESTS OF SOCIETY AND RESPONDENTS.

RECOMMENDATION: SOME MEANS SHOULD BE ESTABLISHED TO EXPEDITE SIGNIFICANTLY THE APPEAL PROCESS AFTER THE REJECTION OF A PATIENT'S APPLICATION FOR VOLUNTARY ADMISSION TO A HOSPITAL FOR MENTAL HEALTH SERVICES.

RECOMMENDATION: ONCE AN INVOLUNTARY COMMITMENT PROCEEDING HAS BEEN INITIATED AND THE RESPONDENT HAS REQUESTED VOLUNTARY ADMISSION, IF THE COURT HAS ANY QUESTION ABOUT WHETHER VOLUNTARY ADMISSION IS APPROPRIATE OR NEEDED, IT SHOULD REQUIRE THE FILING OF A SECOND CERTIFICATE OF EXAMINATION. IF TWO CERTIFICATES ALREADY HAVE BEEN FILED, THE COURT SHOULD EXERCISE ITS AUTHORITY TO REQUIRE ANOTHER, INDEPENDENT EXAMINATION.

RECOMMENDATION: AFTER AN INVOLUNTARY COMMITMENT HAS BEEN INITIATED, A RESPONDENT WHO IS CONSIDERING VOLUNTARY ADMISSION SHOULD BE GIVEN MORE COMPLETE INFORMATION ABOUT WHAT HE OR SHE IS "BUYING"; COUNSEL SHOULD CERTIFY FOR THE COURT THAT SUCH INFORMATION HAS BEEN GIVEN TO THE PATIENT BEFORE THE COURT ACCEPTS THE VOLUNTARY APPLICATION.

Respondent and Patient Rights

RECOMMENDATION: WRITTEN INFORMATION GIVEN TO RESPONDENTS REGARDING THEIR LEGAL RIGHTS AND PROTECTIONS SHOULD BE REWRITTEN IN SIMPLER LANGUAGE.

RECOMMENDATION: TIME AND CARE SHOULD BE TAKEN TO SPEAK PERSONALLY WITH EVERY RESPONDENT IN ORDER TO EXPLAIN CLEARLY THE RESPONDENT'S LEGAL RIGHTS AND PROTECTIONS, AND THE TREATMENT AND COMMITMENT

PROCESS. PRIOR TO THIS CONVERSATION, RESPONDENT SHOULD BE ASKED WHETHER HE OR SHE WISHES TO ENGAGE IN THIS CONVERSATION, SO THAT THIS VERBAL EXPLANATION OF RIGHTS CAN BE WAIVED AT RESPONDENT'S REQUEST.

RECOMMENDATION: THE CERTIFICATE OF EXAMINATION SHOULD BE CHANGED TO INDICATE CLEARLY WHETHER OR NOT THE EXAMINER DISCLOSED THE RESPONDENT'S RIGHT TO REMAIN SILENT DURING THE EXAMINATION AS REQUIRED BY THE STATUTE.

RECOMMENDATION: A PROCEDURE SHOULD BE DEVISED BY WHICH AN INDEPENDENT EXAMINER CAN BE APPOINTED QUICKLY AND INEXPENSIVELY, THIS EXAMINER SHOULD BE INDEPENDENT OF THE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES AND SHOULD BE AVAILABLE FOR EXAMINATIONS AND PRESENTATION OF RESULTS WITHIN A SHORT PERIOD OF TIME.

RECOMMENDATION: THE MENTAL HEALTH CODE SHOULD BE AMENDED TO SPECIFY THAT A RESPONDENT HAS BOTH THE RIGHT TO TESTIFY AND THE RIGHT TO REFUSE TO TESTIFY AT HIS OR HER HEARING. ALTERNATIVELY, THE ILLINOIS CIVIL PRACTICE ACT SHOULD BE AMENDED TO SPECIFY THAT THE RESPONDENT IN A CIVIL COMMITMENT SHALL NOT BE COMPELLED TO TESTIFY AT HIS OR HER HEARING.

RECOMMENDATION: ALL INVOLUNTARILY COMMITTED PATIENTS SHOULD HAVE GUARANTEED ACCESS TO TELEPHONES AND SHOULD BE PROVIDED WITH A REASONABLE SUM OF MONEY UPON REQUEST IF SUCH TELEPHONES ARE PAY TELEPHONES.

Events at the Hearing

RECOMMENDATION: EXAMINERS WHO PREPARE CERTIFICATES SHOULD BE REQUIRED TO REPORT WHAT PSYCHIATRIC RECORDS AND OTHER EXAMINERS THEY CONSULTED WITH BEFORE EXAMINING RESPONDENT AND PREPARING THE CERTIFICATE. THEY SHOULD INDICATE, IF POSSIBLE, WHICH OF THEIR CONCLUSIONS DEPEND SUBSTANTIALLY ON THEIR OWN OBSERVATIONS AND WHICH PRIMARILY ECHO OR REINFORCE PRIOR CONCLUSIONS MADE BY OTHERS.

RECOMMENDATION: WAYS SHOULD BE EXPLORED TO ARRANGE THAT RESPONDENTS WHO CAN AFFORD TO REIMBURSE THE STATE FOR THE EXPENSES OF PROVIDING A PUBLIC DEFENDER SHOULD DO SO, OR SHOULD BE ENCOURAGED TO RETAIN PRIVATE COUNSEL.

RECOMMENDATION: RESPONDENT SHOULD BE REQUIRED TO BE BROUGHT TO EVERY HEARING, EVEN IF A CONTINUANCE IS TO BE REQUESTED BY THE HOSPITAL.

RECOMMENDATION: IT SHOULD BE REQUIRED THAT AT THE TIME OF A JUDICIAL HEARING, THE COURT SHOULD BE INFORMED OF THE COMPLETE HISTORY OF MEDICATION THAT WAS PROVIDED TO THE PATIENT DURING THE PREHEARING PERIOD, AND THE PROBABLE EFFECT THAT IT CURRENTLY HAS ON THE RESPONDENT AND HIS OR HER ABILITY TO ASSIST COUNSEL AND TO TESTIFY IN COURT.

RECOMMENDATION: JUDGES SHOULD FURTHER EMPHASIZE COURTROOM ORDER AND DECORUM.

Matters of Evidence

RECOMMENDATION: THE COURT SHOULD ENCOURAGE THAT SPECIFIC OVERT ACTS OR THREATS BE RECORDED ON MENTAL HEALTH PETITIONS WHENEVER POSSIBLE IN SUPPORT OF THE ALLEGATION THAT A PERSON IS DANGEROUS TO SELF OR OTHERS OR IS UNABLE TO CARE FOR HIS OR HER BASIC PHYSICAL NEEDS.

RECOMMENDATION: EXAMINING PSYCHIATRISTS SHOULD PROVIDE, AT A MINIMUM, A FULL STANDARD MENTAL STATUS EXAMINATION REPORT AS PART OF THE MEDICAL CERTIFICATION.

RECOMMENDATION: INFORMATION ON PREVIOUS PSYCHIATRIC TREATMENT SHOULD BE ADMISSIBLE INTO EVIDENCE AT THE COMMITMENT HEARING FOR PURPOSES OF DIAGNOSIS AND TREATMENT PLANNING, BUT SHOULD NOT BE ACCEPTED AS SUFFICIENT EVIDENCE THAT RESPONDENT MEETS THE CRITERIA FOR COMMITMENT.

RECOMMENDATION: JUDGES SHOULD NOT SEEK PRIMARY INFORMATION ABOUT DANGEROUSNESS FROM EXAMINERS. RATHER, DANGEROUSNESS SHOULD BE INFERRED FROM SPECIFIC THREATS OR OVERT ACTS OF RESPONDENT, REPORTED IN TESTIMONY GIVEN BY PETITIONER AND OTHER WITNESSES.

RECOMMENDATION: AT RECERTIFICATION COMMITMENT HEARINGS, FOLLOWING 60-DAY OR 180-DAY COMMITMENT PERIODS, A REVIEW OF PERIODIC TREATMENT PLANS FROM THROUGOUT THE TREATMENT PERIOD SHOULD BE REQUIRED AS EVIDENCE THAT TREATMENT HAS BEEN PRESENTED AS PLANNED AND HAS BEEN EFFECTIVE.

Less Restrictive Alternatives

RECOMMENDATION: PRIOR TO THE JUDICIAL HEARING, THE MENTAL HEALTH FACILITY SHOULD BE REQUIRED TO MAKE AN INVESTIGATION OF RESPONDENT'S SOCIAL AND FAMILY SITUATION AND PROVIDE THE FINDINGS TO THE JUDGE.

RECOMMENDATION: MORE ATTENTION SHOULD BE GIVEN TO LESS RESTRICTIVE TREATMENT ALTERNATIVES DURING JUDICIAL HEARINGS.

RECOMMENDATION: JUDGES AND ATTORNEYS SHOULD BECOME MORE AWARE OF COMMUNITY-BASED TREATMENT PROGRAMS THAT ARE AVAILABLE AS LESS RESTRICTIVE ALTERNATIVES.

RECOMMENDATION: A SYSTEM SHOULD BE ESTABLISHED SO THAT CURRENT INFORMATION IS READILY ACCESSIBLE ABOUT COMMUNITY-BASED, LESS RESTRICTIVE TREATMENT ALTERNATIVES (LRAs) AND THEIR CAPACITY TO ACCEPT NEW CASES.

RECOMMENDATION: IN SPITE OF ALL THE DIFFICULTIES OF PRESENTING TREATMENT PLANS WITHIN THE FIRST FIVE DAYS OF TREATMENT, TREATMENT PLANS PRESENTED TO THE COURTS DURING COMMITMENT HEARINGS SHOULD BE AS SPECIFIC AS POSSIBLE REGARDING RESPONDENT'S CONDITION AND SHOULD DISCUSS THE POSSIBILITY OF LESS RESTRICTIVE TREATMENT ALTERNATIVES WITHIN THE HOSPITAL.

RECOMMENDATION: CONSIDERATION SHOULD BE GIVEN TO A PRACTICE WHEREBY DETAILED TREATMENT PLANS AND CONSIDERATIONS OF LESS RESTRICTIVE ALTERNATIVES BE UNDERTAKEN ONLY FOR PATIENTS WHO ARE COMMITTED.

RECOMMENDATION: LIAISON SHOULD BE ESTABLISHED BETWEEN THE COURT AND ANY COMMUNITY OUTPATIENT FACILITY TO WHICH A RESPONDENT IS COMMITTED IN ORDER TO PROVIDE FEEDBACK TO THE COURT ABOUT THE PATIENT'S TREATMENT PROGRESS.

RECOMMENDATION: CONSIDERATION SHOULD BE GIVEN TO A STATUTORY CHANGE TO PUT ENFORCEMENT POWER INTO COMMITMENTS TO A LESS RESTRICTIVE ALTERNATIVE.

Professional Duties and Responsiblities

RECOMMENDATION: DOCTORS WHO ARE TO EXAMINE RESPONDENTS AND PREPARE MEDICAL CERTIFICATIONS SHOULD BE REQUIRED TO DISPLAY A MINIMAL FLUENCY IN ORAL AND WRITTEN ENGLISH.

RECOMMENDATION: THE COURT SHOULD CONTINUE TO ENCOURAGE, AND FURTHER ENCOURAGE, PUBLIC DEFENDERS AND OTHER APPOINTED COUNSEL TO ACT IN THE ROLE OF VIGOROUS ADVOCATES FOR THEIR CLIENTS.

RECOMMENDATION: WAYS SHOULD BE IDENTIFIED TO LIGHTEN THE WORKLOAD OF THE PUBLIC DEFENDERS.

RECOMMENDATION: THE MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT SHOULD BE AMENDED SO THAT COUNSEL REPRESENTING CIVIL COMMITMENT RESPONDENTS ARE GUARANTEED FREE ACCESS TO ALL RELEVANT HOSPITAL RECORDS.

RECOMMENDATION: CAREFUL CONSIDERATION SHOULD BE GIVEN TO THE FEASIBILITY OF EXTENDING STAFF AND ACTIVITIES OF THE GUARDIANSHIP AND ADVOCACY COMMISSION IN THE CHICAGO AREA BY HAVING COMMISSION STAFF ACT AS (1) LIAISON TO COMMUNITY OUTPATIENT FACILITIES, (2) PATIENT ADVOCATES, AND (3) GUARDIANS AD LITEM.

Care and Treatment

RECOMMENDATION: A COPY OF THE 30-DAY TREATMENT PLAN, WHICH IS FILED WITH THE COURT, SHOULD BE PROVIDED TO AND REVIEWED BY THE RESPONDENT'S ATTORNEY.

RECOMMENDATION: PROCEDURES SHOULD BE EXPLORED TO FACILITATE THE LEGAL PROCESS OF APPOINTING GUARDIANS FOR RESPONDENTS WHO ARE NOT ABLE TO PROVIDE FOR THEIR BASIC PHYSICAL NEEDS.

RECOMMENDATION: THE COURT AND COMMUNITY CARE-PROVIDERS SHOULD EXPLORE POSSIBLE SOURCES OF PEOPLE WHO COULD BE APPOINTED LEGAL GUARDIANS TO RESPONDENTS WHO ARE NOT ABLE TO PROVIDE FOR THEIR BASIC PHYSICAL NEEDS.

RECOMMENDATION: ADMINISTRATORS OF THE CITY MENTAL HEALTH CLINICS AND STATE HOSPITALS SHOULD DEVELOP AND IMPLEMENT A MORE COOPERATIVE PROCEDURE FOR REFERRING PATIENTS FROM THE CITY CLINICS TO THE STATE HOSPITALS, IN ORDER TO EFFECT A SIGNIFICANTLY LOWER RATE OF ADMISSIONS REFUSALS.

RECOMMENDATION: ALL COMMUNITY MENTAL HEALTH CENTERS THAT HAVE NOT ALREADY DONE SO SHOULD ESTABLISH EFFECTIVE ONGOING LIAISON WITH STATE HOSPITALS TO FACILITATE REFERRAL OF ALL CASES IN THEIR CATCHMENT AREA THAT ARE DENIED VOLUNTARY ADMISSION BY THE HOSPITAL AND ALL PATIENTS WHO

ARE DISCHARGED FROM THE HOSPITAL AND WOULD BENEFIT FROM TRANSITIONAL SUPPORT SERVICES.

RECOMMENDATION: UPON REQUEST FOR INFORMATION ABOUT A PATIENT, HOSPITAL STAFF SHOULD NOT AUTOMATICALLY REFUSE TO PROVIDE THE INFORMATION; RATHER, STAFF SHOULD IMMEDIATELY CHECK WITH THE PATIENT AND INQUIRE WHETHER OR NOT THE PATIENT WISHES TO AUTHORIZE RELEASE OF THE REQUESTED INFORMATION.

Education and Training

RECOMMENDATION: TRAINING SHOULD BE MADE AVAILABLE FOR THE CHICAGO POLICE ON THE NATURE OF MENTAL HEALTH DISORDERS, HOW TO COMMUNICATE WITH AND HANDLE MENTALLY DISORDERED PEOPLE, AND COMMUNITY RESOURCES TO WHICH MENTALLY ILL INDIVIDUALS MAY BE TAKEN.

AN ORIENTATION SHOULD BE GIVEN TO INEXPERIENCED EXAMINERS WHO ARE GOING TO TESTIFY AT A HEARING, PRIOR TO THE TIME THAT THE HEARING BEGINS.

RECOMMENDATION: COURT AND STATE HOSPITAL OFFICIALS SHOULD ARRANGE FOR THE PREPARATION OF A SET OF STANDARD ORIENTATION MATERIALS TO BE USED BY LEGAL AND MENTAL HEALTH PROFESSIONALS WHO BECOME INVOLVED WITH CIVIL COMMITMENT IN CHICAGO.

RECOMMENDATION: COURT AND MENTAL HEALTH PROFESSIONALS SHOULD ARRANGE FOR PERIODIC CONTINUING EDUCATION SEMINARS IN THE CHICAGO AREA TO KEEP PEOPLE WHO WORK IN THIS SYSTEM UP TO DATE ON RELEVANT DEVELOPMENTS IN LAW, MEDICINE, AND SOCIETY.

CHAPTER TWO

COLUMBUS, OHIO: CONCLUSIONS AND RECOMMENDATIONS

The Columbus involuntary civil commitment process can be summarized in terms of nine discrete steps, corresponding roughly to a set of chronologically ordered events: (1) initiating the commitment procedures; (2) mental health screening, investigation, and review; (3) filing of an application (affidavit) formally declaring the intention to cause the involuntary hospitalization of a person; (4) custody and temporary hospitalization of the person (respondent) who is the subject of the affidavit; (5) examination of the respondent by two doctors before judicial hearings; (6) a judicial hearing of probable cause for involuntary civil commitment; (7) continued short-term involuntary hospitalization or release; (8) an adversarial court hearing, resulting in either involuntary civil commitment by the Probate Court, election of voluntary hospitalization by the respondent, or release; and, (9) periodic judicial review of the commitment.

Prehearing Matters Before A Person Is Hospitalized

The involuntary civil commitment process in Columbus that occurs before a respondent is hospitalized is exemplary and praiseworthy in terms of the legal rights and protections afforded the respondent, the opportunities for diversion from compulsory hospitalization, and the apparent economy and effectiveness of the procedures. Although there may be deficiencies, as will be discussed below, these are not major. Perhaps the strongest aspect of the pre-hospitalization procedures in Columbus are the pre-screening of respondents and the investigation and review of the affidavit. These procedures promote fair, prompt, and reliable decision-making. The community mental health center screening, especially, is a model for other jurisdictions to adopt. Another strength in the prehearing process in the persistent and repeated notification of rights. Yet another is the requirement that both emergency and judicial hospitalization be supported by written statements. Deficiencies include a lack of adequate training for peace officers and a lack of coordination of components of the prehearing process. Both the strengths and the weaknesses of the pre-hospitalization process are discussed below.

An important strength of the Ohio law is that it provides only two basic mechanisms (emergency and judicial hospitalization) by which involuntary civil commitment and treatment can be initiated and imposed. Because of the safeguards provided, it would seem difficult to set these mechanisms in motion in Franklin County frivolously or improperly. Emergency hospitalization, potentially abusive to the rights and interests of a respondent, if it could be carried out by any person, can only be carried out by a psychiatrist, licensed clinical psychologist, licensed physician, health officer, parole officer, police officer, or sheriff. These individuals may bring a respondent to the hospital but must provide a written statement, on a prepared form, to the hospital to support emergency hospitalization. The written statement constitutes a

formal application for emergency admission to the hospital and must be completed and signed by the person transporting the respondent to the hospital.

Three recommendations for adjustments in the Franklin County procedures for initiating involuntary civil commitment are proposed. The first two recommendations concern improvements in the access to, and information about, emergency hospitalization procedures provided to mental health and law enforcement personnel; the third proposes an augmentation of the function and status of the "mental illness desk" of the Probate Division of the Franklin County Court of Common Pleas.

RECOMMENDATION: THE PREPRINTED FORM, "APPLICATION FOR EMERGENCY ADMISSION," WHICH SETS FORTH THE REQUIREMENTS FOR THE STATEMENTS SUPPORTING EMERGENCY HOSPITALIZATION, SHOULD BE MADE READILY AVAILABLE TO ALL MENTAL HEALTH AND LAW ENFORCEMENT AGENCIES IN FRANKLIN COUNTY, ALONG WITH DETAILED INSTRUCTIONS FOR ITS USE IN INITIATING EMERGENCY ADMISSION.

A significant proportion (some estimates place it at one-half) of the involuntary civil commitments in Franklin County are initiated by the emergency hospitalization procedures. It, nonetheless, remains relatively mysterious to many of the people interviewed in Franklin County.

RECOMMENDATION: TRAINING SHOULD BE PROVIDED TO LAW ENFORCEMENT PERSONNEL WITHIN FRANKLIN COUNTY BY A CONSORTIUM OF INDIVIDUALS FROM THE PROBATE COURT, THE COMMUNITY MENTAL CENTERS IN FRANKLIN COUNTY, THE CENTRAL OHIO PSYCHIATRIC HOSPITAL, HARDING HOSPITAL, AND THE OHIO LEGAL RIGHTS SERVICE IN THE RATIONALE AND PROCEDURES FOR EMERGENCY HOSPITALIZATION. THE BASIS OF THIS TRAINING SHOULD BE A DETAILED DESCRIPTION OF THE PROCEDURES (PERHAPS, A MANUAL) FOR EMERGENCY HOSPITALIZATION PREPARED BY THE PROBATE COURT.

RECOMMENDATION: IN RECOGNITION OF ITS IMPORTANT SCREENING, COORDINATION, AND PUBLIC RELATION FUNCTIONS, ESPECIALLY IN THE EARLY STAGES OF INVOLUNTARY CIVIL COMMITMENT, THE "MENTAL ILLNESS DESK" SHOULD BE UPGRADED AND BE REFERRED TO AS THE "MENTAL HEALTH REVIEW UNIT" OF THE PROBATE COURT. ONE OF THE THREE PROBATE COURT REFEREES NOT PRESIDING AT JUDICIAL HEARINGS SHOULD BE DESIGNATED AS A "MENTAL HEALTH REVIEW OFFICER," AND THE DEPUTY CLERK CURRENTLY MANNING THE "MENTAL ILLNESS DESK" SHOULD BE DESIGNATED AS THE "MENTAL HEALTH REVIEW ASSISTANT." TOGETHER THESE TWO INDIVIDUALS SHOULD PERFORM ALL REFERRAL AND REVIEW FUNCTIONS FOR THE PROBATE COURT PURSUANT

TO JUDICIAL HOSPITALIZATION AND PARTICIPATE IN TRAINING ACTIVITIES RELATED TO INVOLUNTARY CIVIL COMMITMENT IN FRANKLIN COUNTY.

Once having passed the procedural safeguards, and opportunities for diversion from compulsory hospitalization provided for the respondent in the initiation of involuntary civil commitment (i.e., making the initial contact with the probate court, having the respondent submit to a mental health examination, and obtaining a certificate supporting the affidavit), the affiant is assisted by the Deputy Clerk of the Probate Court in filing and completing the affidavit and other required documents. This is a significant strength in the Columbus procedures occurring before judicial hearings. Nonetheless, several minor improvements in the process of filing an affidavit may be suggested.

Although the language in the Ohio statute relating to what must be contained in an acceptable affidavit may contribute to some of the vagueness of information provided in affidavits, modifications of practices, without legislative reform, seem possible to meet the charge of some attorneys that statements of facts in the affidavits are insufficient.

RECOMMENDATION: THE DEPUTY CLERK, IN ASSISTING THE AFFIANT IN FILING THE AFFIDAVIT AND COMPLETING OTHER REQUIRED FORMS, AND THE REFEREE, IN MAKING HIS OR HER INITIAL EX PARTE DETERMINATION OF PROBABLE CAUSE, SHOULD BE ENCOURAGED TO BE PARTICULARLY DILIGENT IN ENSURING THAT THE AFFIANT'S WRITTEN STATEMENTS ARE SUBSTANTIATED, WHEREVER POSSIBLE, BY REFERENCES TO THE RESPONDENT'S RECENT ALLEGED BEHAVIOR.

RECOMMENDATION: PSYCHIATRISTS, LICENSED PSYCHOLOGISTS, AND THE COMMUNITY MENTAL HEALTH CENTER "PRE-SCREENERS" SHOULD PROVIDE, AT A MINIMUM, THE RESULTS OF A FULL STANDARD MENTAL STATUS EXAMINATION REPORT AS PART OF THEIR CERTIFICATION IN SUPPORT OF AN AFFIDAVIT.

The Columbus procedures for screening, investigation, and reviewing of mental health cases before the respondent is taken into custody are exemplary. There is obviously less curtailment of liberty for those individuals successfully diverted from judicial hospitalization as a result of the initial contact with the Probate Court, the community mental health centers pre-screening, and finally, the ex parte review of the allegations in the affidavit by a referee. The screening procedures, when successful in diverting mentally ill individuals from judicial hospitalization, also embody the best intents of law and mental health practice by providing the opportunity for treatment in a least restrictive environment that is less disruptive of family, social, and economic ties and activities of the respondent.

Although contemplated in most progressive involuntary civil commitment statutes throughout the country, the Ohio law not excepted, it is a rare occurrence, indeed, when a respondent remains at liberty pending a judicial hearing but after an affidavit has been filed. Society simply does not seem willing to bear whatever burden may be involved in maintaining contact with a respondent outside of a hospital during the prehearing period, except in very rare domestic cases. The three screening mechanisms employed in Columbus provide prompt, reliable, and effective decision-making about whether respondents should be taken into custody in the first place. In many jurisdictions throughout the country, it is implied that a respondent may, ideally, remain at liberty between the time an affidavit is filed and the judicial hearing (see Section 5122.17 of the Revised Code noted earlier); however, it is tacitly accepted that a respondent must be taken into custody once an affidavit is accepted by the court.

The screening mechanisms also appear extremely advantageous for the people of Columbus because they seem cost-effective. In the absence of such screening mechanisms (assuming even very conservative estimates of the number of people diverted from judicial hospitalization) it is not inconceivable that judicial costs would soar.

RECOMMENDATION: THE PROBATE COULD SHOULD BE ENCOURAGED TO INCREASE ITS COORDINATION WITH THE THREE COMMUNITY MENTAL HEALTH CENTERS IN COLUMBUS IN SCREENING AND DIVERTING INITIAL REQUESTS FOR JUDICIAL HOSPITALIZATION APPLICATIONS.

RECOMMENDATION: SUFFICIENT FUNDING SHOULD BE PROVIDED FOR MAINTAINING COMMUNITY MENTAL HEALTH CENTER PRE-SCREENING OF POTENTIAL RESPONDENTS.

RECOMMENDATION: A PRE-SCREENING PROCEDURE, MODELED AFTER THAT OF THE SOUTHWEST COMMUNITY MENTAL HEALTH CENTER, SHOULD BE ADOPTED FOR USE THROUGHOUT FRANKLIN COUNTY, IF NOT ALREADY DONE SO.

RECOMMENDATION: THE LEGAL AUTHORITY FOR THE COMMUNITY MENTAL HEALTH CENTER PRE-SCREENING SHOULD BE CLARIFIED BY COURT RULE.

RECOMMENDATION: THE EX PART REVIEW OF THE AFFIDAVIT AND SUPPORTING DOCUMENTS AND THE DETERMINATION OF PROBABLE CAUSE BY HE REFEREE BEFORE THE ISSUANCE OF A TEMPORARY ORDER OF DETENTION SHOULD BE CONDUCTED MORE RIGOROUSLY.

RECOMMENDATION: RESPONDENTS' ATTORNEYS SHOULD HAVE READY ACCESS TO PRE-SCREENING REPORTS.

RECOMMENDATION: THE COURT SHOULD EXPLORE THE POSSIBILITY OF HAVING THE COMMUNITY MENTAL HEALTH CENTER PRE-SCREENER ASSUME THE ROLE OF THE COURT'S EXAMINER.

The practices in Columbus relating to the transportation of respondents in civil commitment proceedings are generally in keeping with the statutory requirement that every reasonable and appropriate effort should be made to take persons into custody in the least conspicuous manner possible (5122.10). With minor exceptions, the procedures employed by the team of sheriff's deputies on special assignment to the Probate Court serve the interests of economy and efficiency. The manner in which police take respondents into custody without prior judicial approval was neither criticized nor praised by those we interviewed in Columbus.

In our opinion, there are a number of minor deficiencies and weaknesses in the custody and detention procedures in Columbus that are worthy of note. We begin with the clothes that the sheriff's deputies wear and the cars that they drive, when they arrive on the scene to take custody of the respondent. To their credit the deputies interviewed noted both the advantages and the disadvantages of the procedures of using uniformed peace officers and marked police cruisers.

RECOMMENDATION: IN NON-EMERGENCY CASES, RESPONDENTS SHOULD BE TAKEN INTO CUSTODY BY PEACE OFFICERS WEARING PLAIN CLOTHES AND DRIVING UNMARKED VEHICLES, UNLESS THE PEACE OFFICERS HAVE REASON TO BELIEVE THAT THE AUTHORITY OF POLICE IDENTIFICATION IS NECESSARY TO RESTRAIN A RESPONDENT. THE NECESSITY OF UNIFORMED POLICE OFFICERS SHOULD BE CONVEYED BY THE DEPUTY CLERK UPON ISSUANCE OF THE TEMPORARY ORDER OF DETENTION.

RECOMMENDATION: COLUMBUS POLICE OFFICERS SHOULD BE ENCOURAGED TO TAKE OR REFER AS MANY ALLEGED MENTAL HEALTH CASES AS POSSIBLE TO COMMUNITY MENTAL HEALTH CENTERS INSTEAD OF CENTRAL OHIO PSYCHIATRIC HOSPITAL.

RECOMMENDATION: ADEQUATE TRAINING SHOULD BE MADE AVAILABLE FOR PEACE OFFICERS IN FRANKLIN COUNTY ON: THE NATURE AND MANIFESTATIONS OF MENTAL HEALTH DISORDERS, HOW TO COMMUNICATE WITH AND HANDLE MENTALLY DISORDERED INDIVIDUALS AND, IMPORTANTLY, COMMUNITY RESOURCES TO WHICH MENTALLY ILL INDIVIDUALS MAY BE TAKEN OR REFERRED.

Court officials, peace officers, mental health personnel, attorneys, and referees in Columbus are extremely conscientious in informing respondents of their rights. Respondents are notified of their rights repeatedly from the time that they are taken into custody until the Probable Cause Hearing. In general, the Columbus procedures for

notification of respondent's rights are exemplary and praiseworthy. In this section, we mention only a few matters for general consideration and make several specific recommendations for making what appears to be a very good system even better.

RECOMMENDATION: IN ACCORDANCE WITH OHIO LAW AND COURT RULES, SHERIFF'S DEPUTIES UPON TAKING A RESPONDENT INTO CUSTODY SHOULD ORALLY INFORM THE RESPONDENT OF HIS OR HER LEGAL RIGHTS, AS WELL AS PROVIDE A WRITTEN STATEMENT OF THOSE RIGHTS.

RECOMMENDATION: WRITTEN STATEMENTS REGARDING LEGAL RIGHTS AND PROTECTIONS SHOULD BE PROVIDED IN SIMPLE LANGUAGE.

RECOMMENDATION: PROCEDURES FOR THE NOTIFYING THE RESPONDENT'S FAMILY SHOULD BE CLARIFIED AND COORDINATED.

RECOMMENDATION: ATTORNEYS SHOULD NOTIFY RESPONDENTS OF THE AVAILABILITY OF APPEAL, WRITS OF HABEAS CORPUS, AND OTHER REMEDIES IN ADDITION TO VOLUNTARY ADMISSION.

Prehearing Matters After A Person Is Hospitalized

The strengths clearly outweigh the weaknesses of procedures in the Columbus involuntary civil commitment process, in the period after a respondent is taken into custody and while he or she is in the hospital awaiting a court hearing. Legal safeguards and protections afforded the respondent are balanced with treatment considerations and interests of economy and efficiency.

The treatment of respondents who are involuntarily hospitalized before a judicial hearing is an issue that raises little controversy in Columbus. In practice, most respondents are medicated and provided other types of therapies shortly after they are admitted to the hospital. Except for their legal status, and some of the hospital staff's trepidations about that status and related liability threats, respondents hospitalized on court order are treated essentially the same as any other patients.

RECOMMENDATION: THE POLICIES OF CENTRAL OHIO PSYCHIATRIC HOSPITAL AND PRIVATE MENTAL HEALTH FACILITIES REGARDING APPROPRIATE TREATMENT OF RESPONDENTS ADMITTED INTO EMERGENCY OR JUDICIAL HOSPITALIZATION SHOULD BE CLARIFIED. THESE POLICIES SHOULD BE INFORMED BOTH BY LEGAL OPINION REGARDING THE LIABILITY OF TREATMENT PROVIDERS IMPLEMENTING THESE POLICIES, AND BY MENTAL HEALTH PERSONNEL'S OPINION ABOUT THE APPROPRIATENESS OF CRISIS TREATMENT. IT IS FURTHER RECOMMENDED THAT THE OHIO DEPARTMENT OF MENTAL HEALTH DRAFT AND

THE OHIO LEGAL RIGHTS SERVICE REVIEW THESE POLICIES.

RECOMMENDATION: UPON FIRST MEETING WITH THEIR CLIENTS, RESPONDENTS' ATTORNEYS SHOULD FAMILIARIZE THEMSELVES WITH THE TYPE OF PREHEARING TREATMENT GIVEN TO THE RESPONDENT, ESPECIALLY WHEN THE TREATMENT CONSISTS OF MEDICATION THAT IS LIKELY TO AFFECT THE RESPONDENT'S DEMEANOR DURING THE PROBABLE CAUSE HEARING.

Taken as a whole, the mental health examinations provided to respondents before judicial hearings--prescreening, hospital examination at the time of admission, examination by a court expert, and examination by an independent expert--constitute a significant strength in the Columbus system. The protection that these examinations provide against improper involuntary hospitalization is substantial. The prescreening examination is performed at the very early stages of the involuntary civil commitment process and provides adequate opportunities for diversion from compulsory hospitalization. Prompt and reliable decision-making appears to be the rule rather than the exception. The legislative intent in Ohio law for the provision of an independent examination is adequately complied with in practice. Such independent examination is provided for in the laws of many states but rarely occurs in practice as it does in Columbus. Given the enormous influence that examiners have in commitment cases, this automatic provision of an independent examination is commendable both from the point of view of a check on the validity of decisions regarding compulsory hospitalizations and an increase in the confidence in diagnosis and appropriate treatment.

On the negative side, the examinations may be redundant and their results underutilized. The prehearing examination process probably could be better coordinated and be economized without lowering safeguards against improper hospitalization.

RECOMMENDATION: THE PROBATE COURT SHOULD MAKE MUCH GREATER USE OF THE INFORMATION THAT IS ACQUIRED IN THE PRESCREENING EXAMINATION BY THE COMMUNITY MENTAL HEALTH CENTER, THE EXAMINATION UPON HOSPITAL ADMISSION, AND THE EXAMINATIONS BY THE COURT AND INDEPENDENT EXPERT.

RECOMMENDATION: ONCE THE INTEREST OF CHECKING THE VALIDITY AND RELIABILITY OF COMMITMENT DECISIONS IS SATISFIED, THE COURT SHOULD COORDINATE AND COMPILE THE RESULTS OF THE VARIOUS PREHEARING EXAMINATIONS, IN THE BEST INTERESTS OF THE RESPONDENT'S TREATMENT, BY MAKING THESE RESULTS AVAILABLE TO THE HOSPITAL TREATMENT TEAM.

RECOMMENDATION: IN THE INTERESTS OF ECONOMY AND EFFICIENCY, THE COURT SHOULD GIVE STRONG

CONSIDERATION TO COMBINING THE PRESCREENING EXAMINATION AND THE EXAMINATION CONDUCTED BY THE COURT EXPERT, THEREBY ELIMINATING THE REQUIREMENT OF ONE OF THESE EXAMINATIONS.

RECOMMENDATION: EXAMINERS SHOULD BE REQUIRED TO COMPLETE THEIR EXAMINATION SUFFICIENTLY IN ADVANCE OF JUDICIAL HEARINGS TO ALLOW COUNSEL ADEQUATE TIME TO CONSIDER THE RESULTS OF THE EXAMINATION IN PREPARING THE CASE FOR JUDICIAL HEARING.

RECOMMENDATION: THE COURTS SHOULD URGE EXAMINERS TO TAKE TIME AND CARE TO EXPLAIN TO EVERY RESPONDENT THE NATURE AND PURPOSE OF THE EXAMINATION, ITS PLACE IN THE COMMITMENT PROCESS, AND THE LIKELY CONSEQUENCES OF THE EXAMINATION.

RECOMMENDATION: EXAMINERS WHO PREPARE WRITTEN CERTIFICATES OR REPORTS SHOULD BE REQUIRED TO INCLUDE IN THOSE REPORTS STATEMENTS INDICATING WHAT PSYCHIATRIC RECORDS AND OTHER EXAMINERS' OPINIONS THEY CONSULTED BEFORE EXAMINING THE RESPONDENT AND PREPARING THEIR CERTIFICATES AND REPORTS. THEY SHOULD INDICATE, IF POSSIBLE, WHICH OF THEIR CONCLUSIONS DEPENDS SUBSTANTIALLY ON THEIR OWN OBSERVATIONS AND THOSE WHICH PRIMARILY ECHO OR REINFORCE PRIOR CONCLUSIONS MADE BY OTHERS.

Notwithstanding the difficult issues of chronically ill persons who are in and out of the "revolving door" of the hospital and the related difficulty of deciding whether a respondent possesses the mental capacity to decide to become a voluntary patient, the procedure of allowing respondents to request voluntary status in the hospital is a definite strength in the Columbus system. It makes it possible for respondents to avoid the stigma of involuntary commitment and prevent the record of a commitment hearing from becoming part of the public record. Further, it seems in the interest of economy to have the majority of respondents enter the mental health system on a voluntary basis, thereby eliminating the need for judicial resources and attorneys.

Two recommendations are made below which may alleviate, but not eliminate, the "revolving door" problem caused by the repeated three-day letter requests for voluntary admissions, and the problem of ascertaining the willingness and competency of respondents to elect voluntary admissions.

RECOMMENDATION: ATTORNEYS FOR RESPONDENTS SHOULD BE ENCOURAGED TO ASCERTAIN AND DETERMINE TO THEIR SATISFACTION THAT RESPONDENTS WHO HAVE APPLIED FOR VOLUNTARY ADMISSION TO THE HOSPITAL HAVE DONE SO WILLINGLY AND WITH SOME UNDERSTANDING.

RECOMMENDATION: ONLY ONE THREE-DAY LETTER REQUESTING RELEASE, FOLLOWING A CONVERSION FROM INVOLUNTARY HOSPITALIZATION TO VOLUNTARY HOSPITALIZATION MAY BE FILED BEFORE A JUDICIAL HEARING, AND ONE EACH BETWEEN ADJUDICATION OF INVOLUNTARY CIVIL COMMITMENT AT A FULL HEARING AND SUBSEQUENT REHEARINGS.

The broad powers to release a respondent, in effect at any time, is clearly a strength in the Columbus involuntary civil commitment system from the standpoint of safeguarding against improper hospitalization. On the other hand, one could argue that if prehearing procedures were conducted properly--i.e., filing of an affidavit, screening, investigation, and ex parte judicial review--the immediate release of a person once he has been taken into custody and transported to the hospital seems senseless, at least from the standpoint of economy and efficiency. As the legal and mental health communities become less concerned with improper compulsory hospitalization and more concerned with the premature release of persons from the hospital who may have no treatment alternatives, discharge and release policies may have to be reviewed. Bed space, resource allocation, and other fiscal concerns may become paramount, if they are not already so.

RECOMMENDATION: HOSPITAL FACILITIES SHOULD BE ENCOURAGED BY THE COURT TO COMMUNICATE CLEARLY TO THE COURT THEIR PREHEARING DISCHARGE POLICIES.

RECOMMENDATION: THE COURT SHOULD PREPARE ITSELF FOR A CHANGE IN PUBLIC SENTIMENT AND CHANGES IN THE LEGAL AND MENTAL HEALTH CULTURE DEMANDING A SHIFT IN ADVOCACY FROM THE RESPONDENT TO THE AFFIANT.

Counsel

The provision and prompt availability of legal representation for persons involuntarily hospitalized in Columbus is a strength in the commitment process, protecting the respondent from wrongful hospitalization for more than a few days. As a group, court appointed attorneys in Columbus advocate conscientiously, at least initially, for responents' expressed wishes. Given the extensive pre-screening and diversion of persons for whom compulsory hospitalization is deemed inappropriate, attorneys in Columbus have assumed roles and attitudes in their representation of respondents that appears effective, though not without room for improvement.

The short period of time available for preparation of a case before a probable cause hearing balances the respondent's right to a quick judicial review and his or her counsel's needs in the preparation of a competent defense. On short notice, access to information relevant to the case is often unavailable to attorneys. Yet, no charges of gross inadequacies of legal counsel provided to respondents were encountered in our study. With minor adjustments and improvements, legal assistance provided to respondents in commitment in Columbus seems deserving of praise, in our opinion.

Although the vast majority of courts throughout the country recognize a constitutional right to counsel in involuntary civil commitment proceedings, the Ohio law is laudable by guaranteeing this right to its citizens. As a group, attorneys for respondents in Columbus seem to have found a comfortable middle ground in their roles somewhere between the extremes of guardian ad litem and zealous advocate. The system works smoothly; we encountered no indications that the role assumed by the attorneys engendered even isolated cases of improper compulsory hospitalization. We found the attorneys' doubt about and questioning of their own roles in the commitment process to be a healthy attitude.

Without exception, attorneys in Columbus seem to assume the role of advocate for release of the respondent in the initial stages of the proceedings. That is, in the absence of contrary information they assume that immediate release of the respondent is the desired goal toward which their representation is aimed. With increased information about a case, however, they may relax their advocacy, as in a case, for example, in which the independent examiner is of the opinion that the respondent is in definite need of immediate compulsory hospitalization. Given that the Columbus system includes an active screening and diversion of respondents before a judicial hearing and a strong adversarial process thereafter, this seemingly prevailing role of strong-advocate-first, then guardian-advisor-later may be the best possible role for attorneys in Columbus.

RECOMMENDATION: THE COURT IS ENCOURAGED TO COMMUNICATE, WITH THE ADVICE OF THE LEGAL AND MENTAL HEALTH COMMUNITIES, THE PREFERRED ROLE FOR RESPONDENT'S COUNSEL, ESPECIALLY TO NEWLY APPOINTED ATTORNEYS.

The methods of appointment and retention of counsel to represent respondents in involuntary civil commitment proceedings in Columbus are effective. The court-appointed attorneys generally are a conscientious and informed group who provide competent legal representation to respondents. The promptness of appointment of counsel, allowing for a timely (although admittedly short) preparation for a defense, is a significant strength in the Columbus civil commitment process. Finally, fee schedules for attorneys appear reasonable and fair given the (1) rotating basis of appointment, (2) the fact that the great majority of respondents are located in one place (Central Ohio Psychiatric Hospital) allowing attorneys expedient access to their clients, (3) the fact that hearings are scheduled reliably on specific predetermined dates, and (4) that several cases are heard at once.

Although the method of appointing attorneys to represent respondents has proved effective in Columbus, the success of the method depends largely upon the individual entrusted with the responsibility of selecting attorneys for court appointment, namely the Franklin County Probate Judge. The following two recommendations concern review of the appointment methods and their results.

RECOMMENDATION: THE PROBATE COURT IS ENCOURAGED TO ASSEMBLE A COMMITTEE OF REPRESENTATIVES FROM THE LOCAL BAR AND MENTAL HEALTH COMMUNITY TO REVIEW AND PROVIDE ADVICE ABOUT THE APPOINTMENT OF ATTORNEYS TO REPRESENT RESPONDENTS IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS.

RECOMMENDATION: THE REVIEW COMMITTEE SHOULD PERIODICALLY MONITOR THE LIST OF COURT APPOINTED ATTORNEYS AND ASSIST THE PROBATE COURT IN EVALUATING COMPLAINTS OF INCOMPETENCE AGAINST ATTORNEYS ON THE LIST AND IN DEVELOPING GUIDELINES FOR THE REMOVAL OF ATTORNEYS FROM THE LIST.

Compared to the legal representation provided to respondents in other jurisdictions, and in consideration of the small amount of time available for preparation of cases before judicial hearing, legal counsel of respondents in Columbus, in our opinion, ranges from satisfactory to very good. Based upon our observations of attorneys during hearings and interviews, it appears that the court-appointed attorneys go about their duties and responsibilities conscientiously. A strength in the representation of respondents in Columbus is the practice of interviewing respondents before the Probable Cause Hearing, whenever possible. Due in part to the short period of time available to attorneys to prepare their cases, however, a weakness in the system is the inability and failure of attorneys to avail themselves of valuable information from pre-screeners, court and independent experts, hospital staff, and other potential witnesses.

RECOMMENDATION: THE RESULTS OF THE PRE-SCREENING INVESTIGATION AND MENTAL HEALTH EXAMINATIONS SHOULD BE PROVIDED TO RESPONDENT'S COUNSEL ALONG WITH A COPY OF THE AFFIDAVIT, AND OTHERWISE BE MADE READILY ACCESSIBLE TO COUNSEL IF NOT PRESENTED TO HIM OR HER IN WRITING.

RECOMMENDATION: WRITTEN STATEMENTS DESCRIBING THE RESULTS OF THE MENTAL HEALTH EXAMINATIONS CONDUCTED BY THE COURT AND INDEPENDENT EXPERTS SHOULD BE MADE AVAILABLE ROUTINELY TO THE RESPONDENT'S COUNSEL AND THE STATE'S ATTORNEY. ALTERNATIVELY, THE PROBATE COURT SHOULD REQUIRE THAT INDEPENDENT AND COURT EXAMINERS COMMUNICATE THE RESULTS OF EXAMINATIONS BY TELEPHONE AT LEAST 24 HOURS BEFORE HEARINGS.

RECOMMENDATION: CENTRAL OHIO PSYCHIATRIC HOSPITAL AND THE PRIVATE HOSIPTALS IN COLUMBUS SHOULD BE ENCOURAGED BY THE PROBATE COURT TO MAKE CONSISTENT THEIR POLICIES REGARDING RESPONDENT'S COUNSEL'S ACCESS TO RELEVANT HOSPITAL RECORDS.

RECOMMENDATION: GIVEN THE INFREQUENT INVOLVEMENT OF COURT-APPOINTED ATTORNEYS IN APPEALS OF INVOLUNTARY CIVIL COMMITMENTS, AND THE OTHERWISE FEW OPPORTUNITIES FOR ATTORNEYS IN COLUMBUS TO REVIEW THE LEGAL AND SOCIAL CONSEQUENCES OF THEIR REPRESENTATION IN COLUMBUS, A CONTINUING EDUCATION PROGRAM FOR COURT-APPOINTED ATTORNEYS SHOULD BE INSTITUTED AND IMPLEMENTED.

Hearings

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.

The provision of court hearings conducted in accordance with due process of law and the Rules of Civil Procedure is a very significant feature of the Columbus civil commitment system. The actors in the

system appear to function fairly, effectively, and efficiently within that system. In our opinion, the Probate Court deserves praise for erecting in practice the procedural and substantive safeguards in Ohio law to protect respondents during hearings. If the system has significant deficiencies, they are due to emphasis of safeguards for the respondent to the detriment of economy and efficiency. Most of our recommendations for improvements are aimed at balancing the interest of the respondent in adequate judicial review and the interest of efficiency and economy.

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.

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.

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.

The timeliness, adversarial nature, and strict adherence to due process of law and the Rules of Civil Procedure are very strong features of the law and practice of the involuntary civil commitment in Columbus. The use of rules of evidence in civil procedure ensure that the hearings will be held in an orderly fashion and that the rights of respondents will be carefully protected. The considerations for improvements of the nature and conduct of full hearings in Columbus suggested below should not detract from our judgment that the manner in which hearings are conducted in Columbus is exemplary.

RECOMMENDATION: THE PROBATE COURT SHOULD SEEK FUNDS TO RENOVATE THE COURTROOM IN CENTRAL OHIO PSYCHIATRIC HOSPITAL.

RECOMMENDATION: REFEREES ARE ENCOURAGED TO BE CONTINUALLY VIGILANT ABOUT MAINTAINING COURTROOM DECORUM.

RECOMMENDATION: THE PROBATE COURT SHOULD ENCOURAGE A CLOSE TRACKING OF STATUTORY CRITERIA AND REQUIREMENTS DURING THE HEARINGS.

RECOMMENDATION: THE PROBATE COURT, IN COLLABORATION WITH THE COMMUNITY MENTAL HEALTH SYSTEM IN COLUMBUS, SHOULD DEVELOP AND KEEP CURRENT INFORMATION ABOUT PROGRAMS IN THE COMMUNITY THAT MIGHT BE APPROPRIATE AND AVAILABLE AS LESS RESTRICTIVE ALTERNATIVES TO INVOLUNTARY COMMITMENT. IT SHOULD BE THE RESPONSIBILITY OF THE RESPONDENT'S COUNSEL AND THE PROBATE COURT TO BE FAMILIAR WITH THIS INFORMATION AND USE IT TO IDENTIFY THE LEAST RESTRICTIVE TREATMENT OPTION THAT IS APPROPRIATE AND AVAILABLE FOR RESPONDENTS.

RECOMMMENDATION: MORE ATTENTION TO AND CONSIDERATION OF TREATMENT PLANS AND LESS RESTRICTIVE TREATMENT ALTERNATIVES TO FORCED HOSPITALIZATION SHOULD BE GIVEN DURING INVOLUNTARY CIVIL COMMITMENT HEARINGS IN COLUMBUS.

A significant strength of the involuntary civil commitment system in Columbus is the conduct of adversarial hearings. The roles of the referee, state's attorney, examiners and other witnesses in the proceedings are generally well executed within this adversarial framework. Also, from the point of view of legal protections, the respondent's presence at hearings in Columbus is a strong feature. Respondents have the opportunity to hear all allegations made about them and are able to assist in their defense to the maximum extent possible. Additionally, the referee always is able to observe the respondent and need not rely solely on the testimony of witnesses and the statements from counsel about the mental condition of the respondent. On the other hand, it can be argued that respondents may suffer emotional and mental damage by the experience of listening to relatives, friends, and doctors testifying about them. Families fear that respondents' relationship with them will suffer as a result of the courtroom experience. Also, as noted earlier, treating physicians believe that their testimony in the presence of the respondent can significantly interfere with their ability to establish a therapeutic relationship with him or her. On balance, however, it is our judgment that the presence of the respondent at hearings, given his or her counsel's good advice, tends to be a mark in favor of the Columbus system.

The assignment of several referees to civil commitment cases on a rotating basis is also a praiseworthy feature of the citys' commitment system. Our interviews with several of the referees and our observations of them during hearings revealed a remarkably competent, conscientious, and fair-minded group of attorneys. They all appear to approach their

part-time job presiding at involuntary civil commitment proceedings with thoughtfulness, intelligence, and enthusiasm.

The following recommendation regarding the State Attorney's function in hearings is made to coincide with earlier recommendations for the abolition of the Probable Cause hearings.

RECOMMENDATION: AN ATTORNEY, DESIGNATED BY THE STATE'S ATTORNEY, SHOULD REPRESENT THE STATE IN ALL CIVIL COMMITMENT PROCEEDINGS.

In our opinion, given the adversarial nature of the civil commitment proceedings in Columbus, a social worker representing the case for hospitalization at a probable cause hearing is an anomaly that detracts from the strength of the Columbus system--namely, the adversarial nature of the proceedings. Insofar as the social worker serves the role of an ersatz attorney, both the appearance and conduct of the hearing are less than adversarial. In our opinion, the aims of economy or informality, if those were the aims of inserting a social worker into the proceedings, are better achieved in other ways.

Judicial Considerations After the Hearing

The courts' concern for individuals involuntarily confined to mental health facilities does not end with judicial commitment hearings. Except for requests for the expungment of all records of the proceedings, for those respondents whose cases are dismissed at the completion of the judicial hearing, the courts' involvement ceases. For those respondents who are involuntarily committed, however, the court continues to be involved in reviewing contested commitments in mandatory periodic hearings, appeal from a commitment order, petitions for writs of habeas corpus, and review of institutional practices, especially questions concerning patients' rights.

Mandatory review hearings conducted in accordance with due process of law are a positive feature of the Columbus involuntary civil commitment system. However, given the rarity of appeals from a commitment order, petitions for writs of habeas corpus, and other legal remedies, the lack of judicial review and oversight is, arguably, a weakness in the system.

From the standpoint of economy and efficiency, the discharge of respondents' attorneys from responsibilities in continued representation of cases following the judicial hearing may have considerable merit. From the standpoint of protection of the respondents' rights, however, this procedure can be critized for, at the least, causing a discontinuity in a respondent's legal representation in civil commitment proceedings, and, at the worst, placing the respondent at a distinct disadvantage in seeking legal remedies for protracted commitment. One solution to the problem, of course, is to require that respondents' attorneys remain responsible for a respondent's legal representation during the commitment period. However, this requirement may prove cumbersome from an administrative point of view. Further, in other jurisdictions (e.g.,

parts of North Carolina) where such continued representation is a matter of law, compliance is minimal, i.e., counsel never maintain contact with their clients after commitment. However, the practice whereby an attorney is discharged from his or her responsibility to a respondent upon completion of the hearing and the respondent literally leaves the courtroom not to see that attorney again is, in our opinion, an anomaly in an otherwise strong system.

RECOMMENDATION: UPON THE COMPLETION OF A JUDICIAL HEARING AND A FINAL ORDER OF COMMITMENT, COUNSEL FOR THE RESPONDENT SHOULD NOT BE DISCHARGED FROM RESPONSIBILITIES FOR RESPONDENT'S REPRESENTATION UNTIL ALL AVAILABLE REMEDIES AND OPTIONS FOR RELEASE OR LESS RESTRICTIVE ALTERNATIVES ARE CLEARLY AND CAREFULLY EXPLAINED TO THE RESPONDENT. FURTHER, COUNSEL FOR THE RESPONDENT SHOULD NOT BE RELEASED FROM HIS OR HER RESPONSIBILITIES FOR THE RESPONDENT'S REPRESENTATION UNTIL HE OR SHE HAS PERSONALLY COMMUNICATED THE PARTICULARS OF THE CASE TO THE OHIO LEGAL RIGHTS SERVICE AND THE HOSPITAL ADVOCATE.

RECOMMENDATION: A DETAILED WRITTEN REPORT, AS REQUIRED IN SECTION 5122.15(H) OF THE REVISED CODE, SHOULD BE FILED BY THE HOSPITAL AND MADE AVAILABLE TO THE RESPONDENT'S COUNSEL AT LEAST THREE DAYS BEFORE A REVIEW HEARING. FURTHER, RESPONDENT'S COUNSEL SHOULD BE ENCOURAGED TO SUBPOENA MEMBERS OF THE TREATMENT TEAM TO TESTIFY AT REVIEW HEARINGS.

RECOMMENDATION: THE PROBATE COURT IS ENCOURAGED TO DEVELOP ONE OR MORE TRAINING SESSIONS FOR REFEREES AND ATTORNEYS ON THE RIGHT TO AND PROCEDURES FOR APPEAL OF COMMITMENT ORDERS. THE PROBATE COURT IS FURTHER ENCOURAGED TO SEEK THE ASSISTANCE OF THE OHIO LEGAL RIGHTS SERVICE IN DEVELOPING AND COORDINATING THESE TRAINING SESSIONS.

CHAPTER THREE

FIRST JUDICIAL DISTRICT, NEW YORK CITY: RECOMMENDATIONS

Prehearing

RECOMMENDATION: A PROCEDURE SHOULD BE DEVELOPED TO PERMIT POLICE OFFICERS TRANSPORTING RESPONDENTS TO HOSPITALS PURSUANT TO THE EMERGENCY ADMISSIONS PROCEDURE TO LEAVE RESPONDENTS IN THE CUSTODY OF THE HOSPITAL WHETHER OR NOT AN EXAMINATION HAS BEGUN. HOSPITAL STAFF SHOULD DEVELOP A STANDARD SET OF QUESTIONS DESIGNED TO ELICIT FROM POLICE OFFICERS INFORMATION ABOUT THE RESPONDENT'S BEHAVIOR DURING THE CUSTODY-TAKING THAT MIGHT BE HELPFUL TO THE PHYSICIAN IN CONDUCTING THE EVALUATION. THESE QUESTIONS SHOULD BE MADE AVAILABLE TO POLICE OFFICERS IN ADVANCE SO THAT RESPONSES MAY BE PRESENTED IN WRITING TO EMERGENCY ROOM STAFF UPON PRESENTATION OF THE RESPONDENT.

RECOMMENDATION: STAFF OF THE HOSPITAL'S ADMISSIONS DEPARTMENT, IN COOPERATION WITH THE HOSPITAL'S PSYCHIATRIC EMERGENCY ROOM STAFF, SHOULD BE RESPONSIBLE FOR OBTAINING FROM RESPONDENTS THE NAMES OF PERSONS TO BE NOTIFIED AND SHOULD PROVIDE SUCH NOTIFICATIONS AS ARE REQUIRED BY STATUTE.

RECOMMENDATION: PHYSICIANS CONDUCTING INITIAL EXAMINATIONS OF RESPONDENTS UPON PRESENTATION FOR ADMISSION SHOULD CAREFULLY EXPLAIN TO RESPONDENTS THEIR STATUS IN THE HOSPITAL AND THEIR RIGHTS AS PATIENTS. MHIS STAFF SHOULD MEET PERSONALLY WITH EVERY RESPONDENT SOON AFTER EMERGENCY ADMISSION TO EXPLAIN CLEARLY HIS OR HER LEGAL RIGHTS AND PROTECTIONS.

RECOMMENDATION: HOSPITAL STAFF AND MHIS ATTORNEYS SHOULD PLACE MORE EMPHASIS ON EXPLORING THE SUITABILITY OF VOLUNTARY STATUS AND SHOULD EXPLAIN FULLY TO RESPONDENTS THEIR OPTION OF ACCEPTING VOLUNTARY STATUS UPON ADMISSION.

RECOMMENDATION: EXAMINING PHYSICIANS SHOULD EXPLAIN TO RESPONDENTS THE PURPOSE OF THE EXAMINATION AND HOW THE INFORMATION GENERATED BY THE EXAMINATION MIGHT BE USED BY STAFF OF THE HOSPITAL AND BY THE COURTS.

RECOMMENDATION: EXAMINING PHYSICIANS SHOULD BE REQUIRED TO HAVE SIGNIFICANT FLUENCY IN ORAL AND WRITTEN ENGLISH.

RECOMMENDATION: IF ANY MEDICATION IS ADMINISTERED TO THE RESPONDENT DURING THE PREHEARING PERIOD AND THE RESPONDENT'S TREATING PHYSICIAN HAS ANY REASON TO BELIEVE THAT THE RESPONDENT'S BEHAVIOR IN COURT WILL BE AFFECTED BY SUCH MEDICATION, THE PHYSICIAN SHOULD INDICATE TO THE COURT, THE RESPONDENT'S ATTORNEY, AND THE ATTORNEY REPRESENTING THE HOSPITAL OR THE STATE WHAT MEDICATIONS WERE ADMINISTERED AND WHAT CONSEQUENCES THESE MEDICATIONS ARE LIKELY TO HAVE ON RESPONDENT'S BEHAVIOR DURING THE HEARING AND ON RESPONDENT'S ABILITY TO ASSIST COUNSEL.

Counsel for the Respondent

RECOMMENDATION: EVERY PATIENT SHOULD BE VISITED SOON AFTER ADMISSION BY A MEMBER OF THE MHIS STAFF. THE MHIS STAFF MEMBER SHOULD INFORM THE PATIENT ABOUT PROCEDURES FOR ADMISSION AND RETENTION AND ABOUT THE PATIENT'S RIGHTS TO CHALLENGE COMMITMENT IN COURT, TO BE REPRESENTED BY COUNSEL, AND TO SEEK INDEPENDENT MEDICAL OPINION. THE MHIS STAFF MEMBER SHOULD TAKE CARE TO ENSURE THAT FAILURE OF PATIENTS TO AVAIL THEMSELVES OF THESE RIGHTS IS DONE KNOWINGLY. THE SIZE OF THE MHIS STAFF SHOULD BE INCREASED SUFFICIENTLY TO ACCOMPLISH ITS STATUTORY GOALS.

RECOMMENDATION: THE NEW YORK STATUTES (29.09) SHOULD BE AMENDED TO PERMIT MHIS ATTORNEYS TO WITHHOLD FROM THE COURT INFORMATION THAT IS PRIVILEGED OR IS ADVERSE TO THE CASE FOR THE DEFENSE.

The Hearing: Determining Committability

RECOMMENDATION: A STATUTORY AMENDMENT SHOULD BE SOUGHT REQUIRING A JUDICIAL HEARING IN EVERY INVOLUNTARY COMMITMENT CASE, TO BE HELD WITHIN 5 DAYS OF THE PATIENT'S ADMISSION TO THE HOSPITAL.

RECOMMENDATION: THE SUPERIOR COURT IN EACH NEW YORK COUNTY SHOULD MONITOR CAREFULLY THE SERVICES PROVIDED BY THE MHIS ATTORNEYS IN ADVISING AND REPRESENTING PERSONS INVOLUNTARILY COMMITTED; WHENEVER THE COURT FINDS THAT THESE SERVICES ARE NOT BEING PROVIDED PROMPTLY AND SUFFICIENTLY, IT SHOULD ORDER THAT A HEARING BE HELD WITHIN 7 DAYS OF ADMISSION.

RECOMMENDATION: REPRESENTATIVES OF THE SUPREME COURT, THE MHIS, AND THE CITY HOSPITALS SHOULD EXPLORE WAYS IN WHICH HEARINGS COULD BE HELD AT LOCATIONS MORE CONVENIENT FOR HOSPITAL PERSONNEL WHO ARE REQUIRED TO ATTEND.

RECOMMENDATION: JUDGES SHOULD STRICTLY ENFORCE PROPER COURTROOM ORDER AND DECORUM.

RECOMMENDATION: JUDGES SHOULD INSIST THAT ALL HEARING PARTICIPANTS BE PRESENT AND PREPARED TO GO FORWARD AT THE TIME SCHEDULED FOR HEARINGS. ATTORNEYS FOR THE HOSPITALS SHOULD ENSURE THAT ALL NECESSARY PAPERS AND WITNESSES ARE AVAILABLE FOR PRESENTATION TO THE COURT.

RECOMMENDATION: WHEN CONTINUANCES ARE NECESSARY, THEY SHOULD BE FOR NO LONGER A PERIOD OF TIME THAN IS NECESSARY TO ACCOMMODATE THE DIFFICULTY REQUIRING A CONTINUANCE. RATHER THAN CONTINUE CASES FOR AN ENTIRE WEEK (UNTIL THE DAY REGULARLY SCHEDULED FOR HEARINGS IN THE PARTICULAR HOSPITAL), JUDGES SHOULD BE PREPARED TO RETURN TO THE HOSPITAL ON ANOTHER DAY DURING THE WEEK IN ORDER TO HEAR CASES REQUIRING CONTINUANCE. ALTERNATIVELY, CASES REQUIRING CONTINUANCE SHOULD BE RESCHEDULED FOR THE HEARING DAY IN THE OTHER HOSPITAL IN WHICH HEARINGS REGULARLY ARE HELD.

RECOMMENDATION: A STATUTORY AMENDMENT SHOULD BE SOUGHT LIMITING TO FIVE DAYS THE TIME FOR WHICH A CONTINUANCE MIGHT BE GRANTED.

RECOMMENDATION: THE STATUTORY PROVISION PROHIBITING CONTINUANCES IN EMERGENCY ADMISSION CASES, UNLESS REQUESTED BY THE PATIENT, SHOULD BE STRICTLY APPLIED.

RECOMMENDATION: STATUTORY AMENDMENTS SHOULD BE SOUGHT TO INCORPORATE THE REQUIREMENTS CONCERNING COMMITMENT CRITERIA AND STANDARD OF PROOF PRESENTED IN SCOPES v. SHAW, AND ADDINGTON v. TEXAS.

RECOMMENDATION: JUDGES SHOULD NOT LOOK PRIMARILY TO EXAMINERS FOR INFORMATION ABOUT DANGEROUSNESS; RATHER, DANGEROUSNESS SHOULD BE INFERRED FROM SPECIFIC THREATS OR VIOLENT ACTS OF RESPONDENT, REPORTED IN TESTIMONY GIVEN BY COMPETENT WITNESSES.

RECOMMENDATION: THE PROCEDURE FOR ASSIGNING JUDGES TO COMMITMENT CASES SHOULD BE CHANGED TO INSURE THAT

JUDICIAL ASSIGNMENTS ARE LENGTHY ENOUGH TO ALLOW THE JUDGE TO BECOME WELL ACQUAINTED WITH THE UNIQUE SUBJECT MATTER OF CIVIL COMMITMENT.

RECOMMENDATION: EVERY JUDGE ASSIGNED TO HEAR COMMITMENT CASES SHOULD BE REQUIRED TO PARTICIPATE IN AN ORIENTATION/EDUCATION PROGRAM PRESENTED PERIODICALLY AS A JOINT EFFORT OF THE MHIS AND THE PSYCHIATRIC HOSPITALS IN NEW YORK CITY. STAFF OF THE MHIS AND PERSONNEL OF THE CITY PSYCHIATRIC HOSPITALS, AS ADVISED BY THEIR COUNSEL, IMMEDIATELY SHOULD ASSUME RESPONSIBILITY FOR DEVELOPING AND IMPLEMENTING SUCH AN EDUCATIONAL PROGRAM.

RECOMMENDATION: TESTIFYING EXAMINING PHYSICIANS SHOULD PRESENT THEIR TESTIMONY IN AN IMPARTIAL MANNER.

RECOMMENDATION: MHIS STAFF, IN COOPERATION WITH COUNSEL FOR THE PSYCHIATRIC HOSPITALS IN NEW YORK CITY, SHOULD DEVELOP AND CONDUCT ORIENTATION/EDUCATION PROGRAMS FOR MENTAL HEALTH PROFESSIONALS WORKING IN THE CITY HOSPITALS. ALTERNATIVELY, BEFORE EACH COMMITMENT HEARING, COUNSEL FOR THE HOSPITAL SHOULD EXPLAIN TO THE TESTIFYING PHYSICIAN WHAT WILL BE EXPECTED OF HIM OR HER DURING THE HEARING.

RECOMMENDATION: COUNSEL SHOULD STRIVE TO PREVENT THE INTRODUCTION OF EVIDENCE THAT IS IN VIOLATION OF THE FORMAL RULES OF EVIDENCE. WHEN TESTIMONY THAT IS HIGHLY OBJECTIONABLE IS GIVEN OVER NO OBJECTION, THE COURT SHOULD ALERT COUNSEL THAT RULES OF EVIDENCE SHOULD BE BETTER FOLLOWED.

RECOMMENDATION: INFORMATION ON PREVIOUS PSYCHIATRIC TREATMENT SHOULD BE ADMISSIBLE INTO EVIDENCE AT THE COMMITMENT HEARING FOR PURPOSES OF DIAGNOSIS AND TREATMENT PLANNING, BUT SHOULD NOT BE ACCEPTED AS SUFFICIENT EVIDENCE THAT RESPONDENT MEETS THE CRITERIA FOR COMMITMENT.

The Hearing: Determining Treatment

RECOMMENDATION: A STATUTORY AMENDMENT SHOULD BE SOUGHT AUTHORIZING JUDGES IN COMMITMENT PROCEEDINGS TO ORDER RESPONDENTS INTO INVOLUNTARY TREATMENT IN PROGRAMS OF CARE LESS RESTRICTIVE THAN HOSPITALIZATION.

RECOMMENDATION: BEFORE ORDERING INVOLUNTARY HOSPITALIZATION, THE COURT SHOULD CONSIDER

WHETHER ANY LESS RESTRICTIVE ALTERNATIVE WOULD BE APPROPRIATE TO ACCOMMODATE THE RESPONDENT'S DISORDER AND SHOULD MAKE A FINDING THAT LESS RESTRICTIVE ALTERNATIVES WERE CONSIDERED AND NONE WAS FOUND TO BE APPROPRIATE.

Posthearing Concerns

RECOMMENDATION: AS REQUIRED BY STATUTE, ANY JUDGE WHO RECEIVES A PETITION FOR A REHEARING SHOULD CAUSE A JURY TO BE SUMMONED UNLESS THE PATIENT OR OTHER PERSON APPLYING FOR THE REHEARING ON THE PATIENT'S BEHALF WAIVES THE TRIAL OF THE FACT BY A JURY AND CONSENTS IN WRITING TO TRIAL OF SUCH FACT BY THE COURT.

RECOMMENDATION: THE APPELLATE DIVISION OF THE SUPREME COURT SHOULD MAINTAIN AN EXPEDITED CALENDAR FOR COMMITMENT APPEALS, WHICH SHOULD ALLOW SUCH APPEALS TO BE HEARD WITHIN FIFTEEN DAYS OF FILING.

RECOMMENDATION: AS REQUIRED BY STATUTE, RESTRAINTS SHOULD BE EMPLOYED ONLY WHEN NECESSARY TO PREVENT A PATIENT FROM SERIOUSLY INJURING SELF OR OTHERS. RESTRAINTS MUST NEVER BE USED AS A PATIENT MANAGEMENT DEVICE. BEFORE ORDERING THE USE OF RESTRAINTS, THE PHYSICIAN SHOULD DOCUMENT IN THE PATIENT'S RECORD THE FACT THAT LESS RESTRICTIVE TECHNIQUES WERE CONSIDERED AND WERE CLINICALLY CONSIDERED TO BE INAPPROPRIATE OR INSUFFICIENT TO AVOID INJURY.

RECOMMENDATION: PATIENTS REFUSING TREATMENT AND APPEALING THE PHYSICIAN'S TREATMENT DECISION, USING THE PROCEDURES OUTLINED IN THE REGULATIONS OF THE MENTAL HYGIENE DEPARTMENT, SHOULD NOT BE TREATED DURING THE APPEALS PROCESS, UNLESS SUCH TREATMENT IS ESSENTIAL TO PRESERVE THE SAFETY OF THE PATIENT OR OTHERS, OR UNLESS A SIGNIFICANT DETERIORATION OF THE PATIENT'S MENTAL HEALTH WILL OCCUR WITHOUT PROMPT MEDICATION OR TREATMENT.

CHAPTER FOUR

LOS ANGELES, CALIFORNIA: CONCLUSIONS AND RECOMMENDATIONS

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, disabilities, or quirks of varying degrees, 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. Or the person may voluntarily admit himself 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 is initiated.

The ease or difficulty with which and by whom involuntary hospitalization can be initiated will determine, to a large extent, the number and types of cases involved in this process. It does not seem difficult, for example, to envision overuse (or abuse) of the civil commitment process if it were 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 crazy 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 a only brief mention of those persons who are authorized to initiate such holds and according to what criteria. 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.), thereby failing to draw notice to the prehospitalization procedures, discussed in this chapter, 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. Gauged by what we would estimate is a major impact on the number and types of cases before Department 95, the procedures, described in this chapter, involved in initiating involuntary

civil commitment but before actual hospitalization (i.e., referral to community "portals," screening and diversion of cases from involuntary hospitalization, and custody-taking) do not seem to be attended to by court personnel in proportion to their importance.

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 accord more weight to them.

RECOMMENDATION: THE COURT SHOULD BECOME FAMILIAR WITH THE IDENTITIES AND 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 (JUDGE, DISTRICT ATTORNEYS, PUBLIC DEFENDERS, AND MENTAL HEALTH COUNSELORS) SHOULD OCCASIONALLY MEET WITH THOSE COUNTY 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. And, 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. (Arguably, a few individuals may be more "free" when involuntarily hospitalized). 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 a 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.

RECOMMENDATION: GATEKEEPERS (PET TEAM MEMBERS 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 PERSON 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 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 the 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 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 OF MOBILE PSYCHIATARIC EVALUATION TEAMS (PET), THROUGHOUT LOS ANGELES COUNTY, 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: SINCE THE PRACTICE IN LOS ANGELES COUNTY PRECLUDES THE USE OF NON-EMERGENCY PROCEDURES PROVIDED IN SECTION 5200 ET SEQ., AND SINCE THIS SECTION PRESCRIBES SAFEGUARDS PROVIDED 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 initial involuntary detention period of 72 hours, 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 and evaluations, and opportunities to assess the persons 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 confinement, 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 as to 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 INTERSIVE 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 attitude, 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 theraputic, relevance. On the one hand, 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 against 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 persons the appearance of being mentally disturbed, which, of course, would work against them during writ hearings.

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 safeguarding against improper hospitalization. However, one could argue that if the pre-hospitalization procedures were diligently and properly conducted (i.e., crisis intervention, screening before application for an emergency 72-hour hold, and admission screening), the immediate release of a person once he has been taken into custody and transported to the hospital seems senseless, at least from the standpoint of economy and efficiency. As the legal and mental health communities become less concerned with improper compulsory hospitalization and more concerned with the premature release of persons from the hospital 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: HOSPITAL FACILITIES SHOULD BE ENCOURAGED BY THE COURT 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.

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)), i.e., a probable cause determination must be afforded every 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 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.

The requirement that a mental health counselor visit every respondent certified for intensive treatment in order to explain rights is an important feature of the California procedure. The fact 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 means 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 post-certification 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 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, 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, as 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 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 OR NOT 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 in order 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 (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 for; and respondents for whom a temporary conservatorship has been created. Further, judicial hearings are mandatory in "post-certification" proceedings concerning a respondent who is believed to be a threat to others to hospitalize 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 the purpose of 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 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. Further, the fact that Public Defenders have little time or opportunity to become involved in prehearing advocacy, or investigation of less restrictive alternatives, is cause for concern. The appropriate allocation of resources in a commitment system, however, is a difficult matter. It would be presumptious, on the basis of our limited study, 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, 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 (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.

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 Commissioner of the conservatorship court frequently to 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 potential 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--have thoroughly examined the respondent and have 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 FIVE

WINSTON-SALEM, NORTH CAROLINA: RECOMMENDATIONS

The Prehearing Process

RECOMMENDATION: IN ORDER TO IMPROVE ACCESS OF PROSPECTIVE PETITIONERS AND THE POLICE TO THE MAGISTRATES, IT IS RECOMMENDED THAT ONE OR MORE OF THE FOLLOWING PROCEDURES BE IMPLEMENTED:

ONLY MAGISTRATES LIVING WITHIN THE CITY LIMITS OF WINSTON-SALEM SHOULD BE AUTHORIZED TO RECEIVE COMMITMENT APPLICATIONS.

A CLERK OR A MAGISTRATE WHO IS AUTHORIZED TO RECEIVE COMMITMENT APPLICATIONS SHOULD BE AVAILABLE AT THE COURTHOUSE AT ALL TIMES.

A SYSTEM SHOULD BE DEVELOPED TO ENABLE PETITIONS FOR INVOLUNTARY COMMITMENTS TO BE SUBMITTED AND APPROVED BY TELEPHONE.

RECOMMENDATION: A STATUTORY AMENDMENT SHOULD BE SOUGHT AUTHORIZING A LAW ENFORCEMENT OFFICER TO TRANSPORT A RESPONDENT DIRECTLY TO A MENTAL HEALTH FACILITY IN AN EMERGENCY SITUATION.

RECOMMENDATION: THE CLERK AND THE MAGISTRATES SHOULD VERY CAREFULLY REVIEW THE ALLEGATIONS OF PETITIONERS BEFORE APPROVING PETITIONS AND ISSUING CUSTODY ORDERS.

RECOMMENDATION: WHENEVER PRACTICAL, PARTICULARLY DURING THE EVENING HOURS AND ON WEEKENDS, ANY LAW ENFORCEMENT OFFICER RESPONSIBLE FOR TRANSPORTING A RESPONDENT TO A MENTAL HEALTH FACILITY FOR EVALUATION SHOULD TELEPHONE THE FACILITY IN ADVANCE OF ARRIVING AND ALERT FACILITY PERSONNEL THAT A RESPONDENT IS TO BE DELIVERED FOR EVALUATION. SUCH A CALL SHOULD BE MADE ONLY AFTER THE OFFICER IS REASONABLY CERTAIN THAT THE RESPONDENT WILL BE TAKEN INTO CUSTODY WITHOUT DELAY. UPON RECEIVING SUCH A CALL, FACILITY PERSONNEL IMMEDIATELY SHOULD MAKE THE NECESSARY ARRANGEMENTS FOR A QUALIFIED PHYSICIAN TO BE AVAILABLE TO EVALUATE THE RESPONDENT AS SOON AFTER THE RESPONDENT'S ARRIVAL AS IS POSSIBLE. IF THE CUSTODY-TAKING IS DELAYED, THE OFFICER IMMEDIATELY SHOULD TELEPHONE THE FACILITY AND REPORT THE DELAY.

RECOMMENDATION: THE OFFICER TAKING THE RESPONDENT TO THE MENTAL HEALTH FACILITY FOR EVALUATION SHOULD REMAIN AT THE FACILITY, IF POSSIBLE, UNTIL THE PHYSICIAN HAS COMPLETED HIS OR HER EVALUATION AND MADE A COMMITTABILITY DETERMINATION; EXCEPT THAT IF IT REASONABLY IS FORESEEN THAT NO PHYSICIAN WILL BE AVAILABLE TO BEGIN THE EVALUATION WITHIN 30 MINUTES OF THE OFFICER'S ARRIVAL AT THE FACILITY, THE OFFICER MAY LEAVE THE RESPONDENT IN THE CUSTODY OF THE FACILITY. IN ANY EVENT, AS IS RECOMMENDED IN THE PREHEARING DISCHARGE SECTION, BELOW, THE OFFICER (OR ANOTHER OFFICER) SHOULD BE AVAILABLE ON SHORT NOTICE TO RETURN THE RESPONDENT TO HIS OR HER HOME OR OTHER PLACE SHOULD THE PHYSICIAN FIND THAT THE RESPONDENT DOES NOT MEET THE COMMITMENT CRITERIA.

RECOMMENDATION: THE CLERK SHOULD INDICATE CLEARLY ON THE "INSTRUCTIONS FOR SERVICE OF INVOLUNTARY COMMITMENT PAPERS" THAT IF THE FACILITY TO WHICH THE LAW ENFORCEMENT OFFICER IS INSTRUCTED TO DELIVER THE RESPONDENT REFUSES TO RECEIVE THE RESPONDENT FOR EVAUATION, THE OFFICER MAY DELIVER THE RESPONDENT TO ANOTHER APPROVED FACILITY FOR EVALUATION.

RECOMMENDATION: IF IT IS NOT POSSIBLE TO COMPLY WITH STATUTORY PROVISIONS IN ALL RESPECTS WITHIN THE ARRANGEMENT OF CONDUCTING HEARINGS ONE DAY PER WEEK, HEARINGS SHOULD BE CALENDERED ON OTHER DAYS AS NECESSARY TO ENSURE COMPLIANCE.

RECOMMENDATION: IT SHOULD BE THE RESPONSIBILITY OF STAFF OF THE FACILITY IN WHICH RESPONDENT IS TO BE DETAINED PENDING A COMMITMENT HEARING TO INFORM RESPONDENT OF HIS OR HER RIGHT TO HAVE FAMILY MEMBERS OR OTHERS NOTIFIED OF THE DETENTION. STAFF SHOULD EXPLAIN TO RESPONDENT THAT, UNLESS HE OR SHE OBJECTS, THE NEXT OF KIN WILL BE NOTIFIED OF THE DETENTION. IF RESPONDENT EXPRESSES A DESIRE TO RESTRICT NOTIFICATIONS OF HIS OR HER DETENTION, THE FACILITY SHOULD RESPECT THIS AND REFRAIN FROM NOTIFYING ANYONE OTHER THAN THOSE REQUIRED BY LAW TO RECEIVE NOTIFICATION OF THE DETENTION.

RECOMMENDATION: REGARDLESS OF HOW MANY EXAMINATIONS ARE REQUIRED, RESPONDENT SHOULD BE EXAMINED SHORTLY BEFORE THE COMMITMENT HEARING, AND THE RESULTS OF SUCH EXAMINATION SHOULD BE MADE AVAILABLE TO THE COURT AT THE HEARING.

RECOMMENDATION: QUALIFIED PHYSICIANS CONDUCTING PREHEARING EXAMINATIONS SHOULD EXPLAIN TO RESPONDENTS THE PURPOSE OF THE EXAMINATION AND THE WAY IN WHICH THE INFORMATION GENERATED BY THE EXAMINATION MIGHT LATER BE USED BY STAFF OF THE MENTAL HEALTH FACILITY AND THE COURTS.

RECOMMENDATION: RESPONDENTS IN INVOLUNTARY CIVIL COMMITMENT PROCEEDINGS WHO HAVE BEEN ADMITTED TO A MENTAL HEALTH FACILITY FOR DETENTION PENDING A HEARING SHOULD BE ACCORDED THE RIGHT TO AN INDEPENDENT EXAMINATION ON REQUEST, TO BE PROVIDED AT THE GOVERNMENT'S EXPENSE IF INDIGENT. NOTICE OF THIS RIGHT SHOULD BE PROVIDED AT THE TIME OF THE EXAMINATION BY THE QUALIFIED PHYSICIAN DESCRIBED IN SECTION 122-58.6. (NO INDEPENDENT EXAMINATION NEED BE PROVIDED AS A CHECK ON THE INITIAL, "SCREENING" EVALUATION CONDUCTED PURSUANT TO SECTION 122-58.4).

RECOMMENDATION: PENDING A COMMITMENT HEARING, RESPONDENT SHOULD BE ACCORDED THE RIGHT TO REFUSE TREATMENT EXCEPT SUCH EMERGENCY TREATMENT AS IS NECESSARY FOR THE PRESERVATION OF THE HEALTH AND SAFETY OF THE RESPONDENT AND THE PROTECTION OF OTHER PERSONS AND PROPERTY. IF ANY MEDICATION IS ADMINISTERED TO RESPONDENT DURING THE PREHEARING DETENTION PERIOD AND RESPONDENT'S TREATING PHYSICIAN HAS ANY REASON TO BELIEVE THAT RESPONDENT'S BEHAVIOR IN COURT WILL BE AFFECTED BY SUCH MEDICATION, THE PHYSICIAN SHOULD INDICATE TO THE COURT IN WRITING WHAT MEDICATIONS WERE ADMINISTERED. REPRESENTATIVES OF THE MENTAL HEALTH COMMUNITY IN WINSTON-SALEM SHOULD PREPARE A BRIEF REFERENCE GUIDE FOR THE USE OF COMMITMENT JUDGES INDICATING THE BEHAVIORAL EFFECTS OF PARTICULAR MEDICATIONS FREQUENTLY USED TO TREAT PSYCHIATRIC PATIENTS.

RECOMMENDATION: BEFORE THE RESPONDENT IS TREATED WITH MEDICATION, THE TREATING PHYSICIAN SHOULD MEET WITH THE RESPONDENT AND INQUIRE WHETHER THE RESPONDENT HAS BEEN TREATED WITH ANTI-PSYCHOTIC OR OTHER PSYCHOTROPIC MEDICATIONS IN THE PAST AND WHETHER, AS A RESULT OF THIS, RESPONDENT HAS A PREFERRED MEDICATION OR TREATMENT.

RECOMMENDATION: UPON A FINDING BY THE QUALIFIED PHYSICIAN CONDUCTING THE SECOND EVALUATION OF THE RESPONDENT (OR THE FIRST IF THE RESPONDENT WAS DETAINED PURSUANT TO THE EMERGENCY PROCEDURE OR UPON AN AFFIDAVIT SUBMITTED BY A QUALIFIED

PHYSICIAN) THAT THE RESPONDENT DOES NOT MEET THE INVOLUNTARY COMMITMENT CRITERIA, THE RESPONDENT SHOULD BE DISCHARGED FROM THE FACILITY AND FACILITY PERSONNEL WITHOUT DELAY SHOULD COMMUNICATE THIS FACT TO THE CLERK OF THE COURT IN WHICH THE HEARING IS PENDING. THE CLERK WITHOUT DELAY SHOULD NOTIFY THE RESPONDENT'S COUNSEL, THE DISTRICT ATTORNEY, THE PETITIONER, AND ANY WITNESSES WHO MAY HAVE BEEN SUMMONED TO APPEAR AT THE HEARING THAT THE RESPONDENT HAS BEEN FOUND NOT TO MEET THE COMMITMENT CRITERIA AND HAS BEEN DISCHARGED. NEITHER THE RESPONDENT NOR THE RESPONDENT'S COUNSEL SHOULD BE REQUIRED TO APPEAR IN COURT ON THE DAY OF THE SCHEDULED HEARING, AND THE COURT SHOULD DISMISS THE PROCEEDINGS AGAINST THE RESPONDENT. THE ATTORNEY APPOINTED TO REPRESENT THE RESPONDENT AT THE HEARING SHOULD BE COMPENSATED DESPITE THE RESPONDENT'S PREHEARING RELEASE. BEFORE MAKING A FINDING THAT THE RESPONDENT DOES NOT MEET THE COMMITMENT CRITERIA, THE PHYSICIAN CONDUCTING THE SECOND EVALUATION OF THE RESPONDENT SHOULD BE PERMITTED TO CONSULT THE PHYSICIAN WHO CONDUCTED THE INITIAL EVALUATION AND DETERMINE WHETHER THERE ARE FACTS OR OTHER EVIDENCE THAT WOULD RENDER A FINDING OF NONCOMMITTABILITY INAPPROPRIATE.

Counsel for Respondent

RECOMMENDATION: THE COURTS AND THEIR ALLIED AGENCIES IN WINSTON-SALEM SHOULD STUDY THE POSSIBILITY OF CREATING A NEW SYSTEM FOR PROVIDING COUNSEL TO INDIGENTS IN INVOLUNTARY COMMITMENT CASES. OTHER SYSTEMS THAT SHOULD BE INVESTIGATED INCLUDE THE TYPE USED IN NEW YORK (THE MENTAL HEALTH INFORMATION SERVICE, AN ADVOCACY ORGANIZATION RESPONSIBLE PRIMARILY FOR REPRESENTING THE INTERESTS OF PATIENTS IN PSYCHIATRIAC HOSPITALS), THE PUBLIC DEFENDER SYSTEM (USED, FOR EXAMPLE, IN CHICAGO, ILLINOIS), AND THE SPECIAL COUNSEL SYSTEM USED IN THE REGIONAL FACILITIES IN NORTH CAROLINA.

RECOMMENDATION: ASSIGNMENT OF COUNSEL ALWAYS SHOULD BE MADE AT LEAST 48 HOURS BEFORE THE TIME SCHEDULED FOR HEARING.

RECOMMENDATION: THE COURT SHOULD SPONSOR PERIODIC SEMINARS ON THE INVOLUNTARY CIVIL COMMITMENT PROCESS IN WINSTON-SALEM AND THE ROLE OF RESPONDENT'S COUNSEL IN THIS PROCESS. NO ATTORNEY SHOULD BE ELIGIBLE TO RECEIVE

APPOINTMENTS OF COMMITMENT CASES UNTIL HE OR SHE HAS EITHER ATTENDED SUCH A SEMINAR OR VIEWED A FILM OR VIDEO TAPE OF SUCH A SEMINAR.

RECOMMENDATION: THE ROLE OF RESPONDENT'S COUNSEL SHOULD BE DISCUSSED AND EXPLORED BY THE WINSTON-SALEM LEGAL AND MENTAL HEALTH COMMUNITIES. SERIOUS ATTENTION SHOULD BE GIVEN TO THE NATIONAL TRENDS AND REASONS FOR HAVING COUNSEL ASSUME A STRONG ADVOCACY ORIENTATION.

RECOMMENDATION: COUNSEL FOR RESPONDENT SHOULD BE REQUIRED TO MEET WITH RESPONDENT AND DISCUSS RESPONDENT'S CASE AT LEAST ONE DAY BEFORE THE HEARING DATE. IF IT IS DETERMINED THAT COUNSEL FAILED TO COMPLY WITH THIS REQUIREMENT, THE COURT SHOULD REFUSE TO COMPENSATE COUNSEL FOR SERVICES RENDERED AND SHOULD OFFER THE RESPONDENT THE OPPORTUNITY TO HAVE HIS OR HER CASE ADJOURNED IN ORDER FOR NEW COUNSEL TO BE ASSIGNED TO REPRESENT RESPONDENT. FURTHER, UNLESS COUNSEL IS ABLE TO PROVIDE AN ADEQUATE REASON FOR FAILING TO COMPLY WITH THIS REQUIREMENT, HE OR SHE SHOULD BE REMOVED FROM THE LIST OF ATTORNEYS ELIGIBLE FOR APPOINTMENTS OF COMMITMENT CASES.

RECOMMENDATION: RESPONDENT'S ATTORNEY SHOULD BE PROVIDED ACCESS TO RESPONDENT'S HOSPITAL RECORDS REGARDLESS OF WHETHER RESPONDENT HAS PROVIDED EXPRESSED PERMISSION.

RECOMMENDATION: AT THE TIME THAT THE EXAMINING PHYSICIAN SENDS HIS OR HER REPORT TO THE COURT, HE OR SHE ALSO SHOULD SEND A COPY OF THE REPORT TO RESPONDENT'S ATTORNEY.

RECOMMENDATION: RESPONDENT'S COUNSEL SHOULD MAKE AN EFFORT TO NOTIFY IN ADVANCE PERSONNEL OF A FACILITY WHEN HE OR SHE WISHES TO SPEAK WITH A PHYSICIAN AT THE FACILITY; UPON RECEIVING SUCH NOTIFICATION, THE FACILITY PERSONNEL SHOULD ATTEMPT TO ARRANGE FOR THE PHYSICIAN TO BE AVAILABLE TO MEET WITH RESPONDENT'S COUNSEL.

RECOMMENDATION: THE JUDGES OF THE DISTRICT COURT SHOULD DISCUSS AND EXPLORE THE POSSIBILITY OF ESTABLISHING GUIDELINES FOR ORDERING HIGHER-THAN-USUAL FEES TO COUNSEL FOR RESPONDENTS IN INVOLUNTARY COMMITMENT PROCEEDINGS AND SHOULD NOTIFY THE LOCAL BAR OF ANY GUIDELINES ESTABLISHED.

Hearing Concerns

RECOMMENDATION: RESPONDENT'S ATTENDANCE AT HIS OR HER HEARING SHOULD BE MANDATORY UNLESS RESPONDENT'S ATTENDING PHYSICIAN STATES IN WRITING THAT RESPONDENT'S APPEARANCE IN COURT WOULD SUBSTANTIALLY IMPAIR RESPONDENT'S MENTAL OR EMOTIONAL STABILITY OR WOULD SERIOUSLY THREATEN THE SAFETY OF OTHERS.

RECOMMENDATION: UNDER ORDINARY CIRCUMSTANCES, THE FINDINGS OF THE EXAMINING PHYSICIAN SHOULD NOT BE ADMITTED INTO EVIDENCE UNLESS PRESENTED IN ORAL TESTIMONY BY SUCH PHYSICIAN. SHOULD THE COURT NOT WISH TO REQUIRE THE ATTENDANCE OF PHYSICIANS AT HEARINGS, A TELEPHONE COMMUNICATIONS SYSTEM SHOULD BE USED TO ENABLE EXAMINING PHYSICIANS TO PRESENT THEIR TESTIMONY AND SUBMIT TO CROSS EXAMINATION BY TELEPHONE. SUCH A SYSTEM SHOULD INCLUDE RECEPTION, TRANSMISSION, AND AMPLIFICATION EQUIPMENT CAPABLE OF ALLOWING ALL OF THE PARTICIPANTS IN THE HEARING TO HEAR THE TESTIMONY OF THE EXAMINING PHYSICIAN AND DIRECT QUESTIONS TO HIM OR HER. SHOULD THE COURT DECIDE NOT TO USE SUCH A SYSTEM, IT SHOULD REFUSE TO ALLOW RESPONDENT'S COUNSEL TO STIPULATE TO THE REPORT OF THE EXAMINING PHYSICIAN ABSENT A REPRESENTATION BY RESPONDENT'S COUNSEL THAT HE OR SHE DISCUSSED THE POSSIBLE CONSEQUENCES OF THE STIPULATION WITH RESPONDENT AND RESPONDENT ACQUISCED IN THE STIPULATION.

RECOMMENDATION: ALL REPORTS SUBMITTED TO THE COURT BY EXAMINING PHYSICIANS SHOULD BE TYPED.

RECOMMENDATION: THE STATUTE REQUIRING THAT COMMITMENT HEARINGS BE CLOSED UNLESS THE RESPONDENT REQUIRES OTHERWISE SHOULD BE AMENDED TO ALLOW THE COURT TO MAKE EXCEPTIONS FOR RESEARCHERS AND OTHERS HAVING A COMPELLING SOCIAL INTEREST IN ATTENDING AND WHOSE ATTENDANCE WOULD HAVE NO FORESEEABLE DETRIMENTAL EFFECT ON THE INTERESTS OF RESPONDENT.

RECOMMENDATION: MEASURES SHOULD BE TAKEN TO ENSURE THAT THE PUBLIC CAN NEITHER VIEW NOR LISTEN TO COMMITMENT HEARINGS.

RECOMMENDATION: THE COURT SHOULD INVESTIGATE THE FEASIBILITY OF SEQUESTERING RESPONDENTS FROM THE COURTROOM DURING HEARINGS IN WHICH THEY ARE NOT INVOLVED.

RECOMMENDATION: COUNSEL FOR THE STATE AND FOR THE RESPONDENT SHOULD STRIVE TO PREVENT THE INTRODUCTION OF EVIDENCE THAT IS IN VIOLATION OF THE FORMAL RULES OF EVIDENCE. WHEN TESTIMONY THAT IS HIGHLY OBJECTIONABLE IS GIVEN OVER NO OBJECTION, THE COURT SHOULD ALERT COUNSEL THAT RULES OF EVIDENCE SHOULD BE BETTER FOLLOWED.

RECOMMENDATION: BEFORE ORDERING INVOLUNTARY TREATMENT, THE COURT SHOULD CONSIDER WHETHER ANY LESS RESTRICTIVE ALTERNATIVE WOULD BE APPROPRIATE TO ACCOMODATE RESPONDENT'S DISORDER AND SHOULD MAKE A FINDING THAT LESS RESTRICTIVE ALTERNATIVES WERE CONSIDERED AND NONE WAS FOUND TO BE APPROPRIATE. BEFORE ORDERING INPATIENT TREATMENT, THE COURT SHOULD CONSIDER WHETHER INVOLUNTARY OUTPATIENT TREATMENT WOULD BE APPROPRIATE AND SHOULD MAKE A FINDING THAT OUTPATIENT TREATMENT WAS CONSIDERED AND THAT IT WAS FOUND NOT TO BE APPROPRIATE.

RECOMMENDATION: THE COURT, IN COLLABORATION WITH THE LOCAL MENTAL HEALTH ASSOCIATION AND OTHER AGENCIES, SHOULD DEVELOP AND KEEP CURRENT INFORMATION ABOUT TREATMENT PROGRAMS IN THE COMMUNITY THAT MIGHT BE APPROPRIATE AND AVAILABLE AS LESS RESTRICTIVE ALTERNATIVES TO INVOLUNTARY COMMITMENT FOR RESPONDENTS IN COMMITMENT PROCEEDINGS. IT SHOULD BE THE RESPONSIBILITY OF RESPONDENT'S COUNSEL AND THE COURT TO BE FAMILIAR WITH THIS INFORMATION AND USE IT TO IDENTIFY THE LEAST RESTRICTIVE TREATMENT OPTION THAT IS APPROPRIATE AND AVAILABLE FOR RESPONDENTS.

RECOMMENDATION: THE ASSISTANT DISTRICT ATTORNEY RESPONSIBLE FOR REPRESENTING THE STATE IN COMMITMENT PROCEEDINGS IN WINSTON-SALEM SHOULD BE AUTHORIZED TO DISCHARGE THE RESPONSIBILITIES IMPOSED BY STATUTE ON THE ATTORNEY GENERAL IN SUPPLEMENTAL HEARING PROCEEDINGS TO CONVERT ALLEGEDLY NON-COMPLAINT, INVOLUNTARY OUTPATIENTS TO INVOLUNTARY INPATIENT STATUS. FURTHER, THE COURT SHOULD ENCOURAGE STAFF OF THE TREATMENT FACILITIES PROVIDING INVOLUNTARY OUTPATIENT CARE TO USE THE SUPPLEMENTAL HEARING PROCEDURE TO CONVERT NONCOMPLIANT, INVOLUNTARY OUTPATIENTS TO INPATIENT STATUS.

Posthearing Concerns

RECOMMENDATION: IT SHOULD BE THE RESPONSIBILITY OF STAFF OF THE FACILITY IN WHICH RESPONDENT IS COMMITTED TO INFORM RESPONDENT OF HIS OR HER

RIGHT TO HAVE FAMILY MEMBERS AND OTHERS (WITHIN REASON) NOTIFIED OF THE COMMITMENT AND OF ANY SUBSEQUENT DISCHARGE. STAFF SHOULD EXPLAIN TO RESPONDENT THAT UNLESS HE OR SHE OBJECTS, THE NEXT OF KIN OR GUARDIAN WILL RECEIVE SUCH NOTIFICATION. IF RESPONDENT EXPRESSES A WISH THAT PARTICULAR PERSONS NOT RECEIVE NOTIFICATION, THE FACILITY SHOULD REFRAIN FROM NOTIFYING SUCH PERSONS UNLESS REQUIRED BY LAW TO DO SO.

RECOMMENDATION: IMMEDIATELY FOLLOWING AN ORDER OF COMMITMENT, RESPONDENT'S COUNSEL SHOULD EXPLAIN TO RESPONDENT HIS OR HER RIGHT TO APPEAL AND SHOULD BE AVAILABLE TO PURSUE AN APPEAL FOR RESPONDENT IF RESPONDENT SO DESIRES AND THERE IS A LEGITIMATE GROUND FOR APPEAL. THE JUDGES OF THE DISTRICT COURT, TOGETHER WITH THE JUDGES OF THE COURT OF APPEALS, SHOULD DEVELOP A POLICY FOR COMPENSATING APPOINTED COUNSEL PURSUING AN APPEAL ON RESPONDENT'S BEHALF AND SHOULD NOTIFY THE LOCAL BAR OF THIS POLICY. THE COURT OF APPEALS SHOULD MAINTAIN AN EXPEDITED CALENDAR FOR COMMITMENT APPEALS, WHICH WOULD ALLOW SUCH APPEALS TO BE HEARD WITHIN FIFTEEN DAYS OF FILING.

RECOMMENDATION: A COPY OF THE PETITION FOR TRANSFER SHOULD BE SERVED ON THE PATIENT AND THE PATIENT'S COUNSEL AT LEAST 48 HOURS PRIOR TO THE PROPOSED TRANSFER. THE PATIENT SHOULD BE GIVEN A RIGHT TO A HEARING, ON REQUEST, TO CHALLENGE THE PETITION FOR TRANSFER BEFORE A JUDGE OF THE DISTRICT COURT WITHIN THE 48-HOUR PERIOD. NOTICE OF THIS RIGHT SHOULD BE PROVIDED TO THE PATIENT AND THE PATIENT'S ATTORNEY WITH THE PETITION. THE PATIENT'S ATTORNEY SHOULD BE RESPONSIBLE FOR REPRESENTING THE PATIENT AT THE HEARING, IF ONE IS REQUESTED. IF THE PATIENT IS NOT REPRESENTED BY COUNSEL, COUNSEL SHOULD BE APPOINTED. THE JUDGES OF THE DISTRICT COURT SHOULD DEVELOP A POLICY FOR COMPENSATING APPOINTED COUNSEL FOR THIS REPRESENTATION AND SHOULD NOTIFY THE LOCAL BAR OF THIS POLICY.

RECOMMENDATION: PERSONS RESPONSIBLE FOR DISCHARGE PLANNING AT THE FACILITIES IN WINSTON-SALEM SHOULD MORE FREQUENTLY CONSIDER CONDITIONAL RELEASE AS A DISCHARGE OPTION.

RECOMMENDATION: UNLESS A SYSTEM IS DEVELOPED IN WINSTON-SALEM WHEREBY A SPECIAL COUNSEL IS DESIGNATED TO BE RESPONSIBLE FOR REPRESENTING RESPONDENT'S INTERESTS DURING THE PERIOD OF COMMITMENT, COUNSEL ASSIGNED TO REPRESENT

RESPONDENT AT THE INITIAL HEARING SHOULD BE REQUIRED TO REMAIN RESPONSIBLE FOR RESPONDENT'S REPRESENTATION DURING THE COMMITMENT PERIOD (AS REQUIRED BY LAW). IN ORDER FOR SUCH POST-COMMITMENT REPRESENTATION TO BE EFFECTIVE, COUNSEL SHOULD BE REQUIRED TO HAVE CONTACT BY MAIL, BY TELEPHONE, OR IN PERSON, WITH RESPONDENT OR OTHERWISE BE AVAILABLE AT THE FACILITY IN WHICH RESPONDENT IS DETAINED AT LEAST MONTHLY DURING THE PERIOD OF COMMITMENT.