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# Civil Commitment in Mental Health: A Review of the Lanterman-Petris-Short Act

Senate Subcommittee on Mental Health, Developmental Disabilities and Genetic Diseases

Assembly Select Committee on Mental Health

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Joint Interim Hearing

SENATE SUBCOMMITTEE ON  
MENTAL HEALTH, DEVELOPMENTAL DISABILITIES  
AND GENETIC DISEASES  
AND  
ASSEMBLY SELECT COMMITTEE  
ON MENTAL HEALTH

“Civil Commitment in Mental Health:  
A Review of the Lanterman-Petris-Short Act”

October 1, 1984  
State Capitol, Room 4202  
9:00 a.m.

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**JOINT INTERIM HEARING**

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DISABILITIES AND GENETIC DISEASES  
AND  
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**"CIVIL COMMITMENT IN MENTAL HEALTH:  
A REVIEW OF THE LANTERMAN-PETRIS-SHORT ACT"**

**OCTOBER 1, 1984  
STATE CAPITOL, ROOM 4202  
9:00 A.M.**

MEMBERS  
DAN MCCORQUODALE  
CHAIRMAN  
WILLIAM CAMPBELL  
HERSCHEL ROSENTHAL

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COMMITTEE SECRETARY

# California Legislature

## Senate Subcommittee

on

## Mental Health, Developmental Disabilities and Genetic Diseases

### JOINT INTERIM HEARING

SENATE SUBCOMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL  
DISABILITIES AND GENETIC DISEASES

AND

ASSEMBLY SELECT COMMITTEE ON MENTAL HEALTH

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9:00 a.m.

### A G E N D A

Opening statements: Senator Dan McCorquodale  
Assemblyman Bruce Bronzan  
Senator Alan Short

Overview of LPS: o Carl Elder, Chief Counsel, Department  
Mental Health  
o Barbara Lurie, Chief, Patients' Rights  
Advocacy Program, Los Angeles County  
Department of Mental Health

#### Panel 1 - The Patients' Perspectives

- o Marjorie Schwartz, American Civil Liberties Union
- o Colette Hughes, Esq., Title IX Patient's Rights Advocates
- o Jean Matulis, California Network of Mental Health Clients

Panel 2 - Clinical/legal issues

- o Byron Chell, Esq., Author: "After a Decade of LPS - Uncertain Times in Mental Health Law"
- o Dave Meyer, Esq., Head Deputy Public Defender, Los Angeles County
- o Captane Thomson, M.D., California Psychiatric Assoc.
- o Beverly Abbott, President, Conference of Local Mental Health Directors

Panel 3 - The System's Monitors

- o Helen Teisher, President, California Alliance for the Mentally Ill
- o Jack Cunningham, Citizens Advisory Council
- o Derek Washington, Ph.D., Mental Health Association of California

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CHAIRMAN MCCORQUODALE: Good morning and welcome to this Joint Interim Hearing on Mental Health. I'd like to introduce the other legislators who are here. We have Bruce Bronzan, who's Chair of the Assembly Select Committee on Mental Health, and Mr. Curtis Tucker, who's Chair of the Assembly Health Committee. Pleased to have them here this morning.

This is the first collaboration between the Assembly Select Committee on Mental Health and the Senate Subcommittee on Mental Health, but hopefully it will not be our last. We intend to continue to address the mental health needs of California residents through this hearing and future joint ventures.

Our goal today is to hear from three panels comprised of individuals specifically invited because of their expertise and their representation of varying viewpoints on the various aspects of the Lanterman-Petris-Short Act. The LPS Act, law since 1969, governs the methodology and procedure for civil commitment of persons with mental illness. Other similar procedures on involuntary commitment have been replaced in almost every other state in the Union based upon the LPS model.

We do not expect to be able to arrive at a definitive conclusion regarding civil commitment issues as a result of today's short hearing. However, we hope that by addressing these issues we will be able to determine if indeed these are the issues that need legislative clarification during the upcoming legislative session.

Following the hearing we plan to encourage the informal establishment of an ad hoc legislative work group comprised of the various elements of the mental health delivery and advocacy system. This group will be asked to expand upon the issues and recommendations presented at this hearing and will be asked to formulate specific legislative proposals for revising the LPS Act if revision is seen as necessary.

The resulting bill, or package of bills, would then be introduced during the early spring months of the 1985-86 legislative session. Presenting the package as two-year bills would give all interested parties ample time to review and make recommendations on the legislative package, and in order to work out the details over two years to ensure successful passage.

We have with us today one of the three of the Lanterman-Petris-Short Act. Alan Short is with us and I'm going to ask him to make some comments first and then we will go to Carl Elder from the Department of Mental Health, Barbara Lurie from the Los Angeles County Office of Patients' Rights to summarize the key provisions and procedures and the legal implications of the LPS Act. We then have a group of individuals who will follow that. I'd like to call on Senator Short to make some comments.

SENATOR ALAN SHORT: I have Jim McDowell with me, Mr. Chairman and members of the committee, and he represents the right wing group that we have of volunteers trying to do something in the field of mental health.

I'd like to thank you for inviting me to come today. It is true that the last

amendment that went in the bill named the bill. Actually, it's a Senate Bill. The work was done on the Assembly side and then we put in this report, and I assume that you have a copy of this report.

I had a very innocent bill that raised the amount of money that the state was going to give counties and cities under the Community Mental Health Act. I think they've changed it from 50 to 75 percent. I may be wrong on that. It's been some time. A very innocent bill, just a question of whether the state could fund it. We did get it by the Senate and through the committees on the Assembly side and it was hijacked by Mr. Lanterman. I said, "Can't you get another bill, because they really need the money at the local mental health clinics." He said, "No, this is it." And he admitted, he said, "We need your support. Senator Teale on the Senate side is giving us fits and he's a doctor and he doesn't like the bill." I read the bill and I didn't like it myself. So we had some meetings in my office and, of course, Frank Lanterman was a gentleman that worked exceedingly hard in the field of mental health, and had the respect of every member of the Legislature. And if I could conceivably help him I wanted to do it. And he also had as a consultant to his committee one of the brightest men I've ever met, Art Boten. We have several judges from Stockton come up and discuss the legal aspects of the bill and a director of our community facility in San Joaquin County, and as a former supervisor you understand what you have to go through a lot better than I do. So we prepared many, many amendments to the bill. And I was a little bit shocked at the ease with which Frank said yes, we'll take them. And then we gave him another block of amendments. Yes we'll take them. Well, those committed and we ran with the bill.

I agree with you wholeheartedly that the bill needs a good look at. How to get a person in a state hospital. But you understand, of course, at the time they did the study, and I assume you've read this report, and to me it was a marvelous report because it showed that people were not getting due process of law; people were going to the state hospital because they had no other place to put them. They didn't have the rights of a criminal, and it was time to stop it. There were people in the state hospital that didn't belong there. They were iatrogenic, a nice Greek word that means "doctor caused." They were so low you were making them ill. So this marvelous report was a background of the LPS Act and I assume you have it. If you don't, I'll be happy to give it to you.

Now, this is the last report of the Senate Committee on the Treatment of the Mentally Ill, 1959. Another of our six reports were written by anybody but the staff in the office and some of them looked like it, but at least we got the job done. This last report, and they're hard to come by, I will leave with you, because on the last section of it it certainly gives my philosophy on this whole field. And I hope, Mr. Bronzan, you will give it a good look, and Senator, because that's what I believe in.

Now, I follow in the newspaper, like Will Rogers, things that are happening in the mental health field. Here you have the magazine - I'm pretty sure that most of you get -

the California Journal, and the June issue - and I'll leave this with you, Mr. Chairman - it says, "Thousands Released, Few Treatment Facilities." "The state's first legislative step along this road was in 1957. The Short-Doyle Act would set up a procedure for state funding of county programs. Next came the Lanterman-Petris-Short Act (1967) which made it far more difficult to commit mentally ill persons to state hospitals and keep them there. The number of patients in the state hospitals declined dramatically but the community systems did not take up the slack," and it goes on and on, and that quotes Michael O'Connor that we had 37,500 in the state hospitals, now we have 5,000. I'm sure he's here today and can speak for himself. I did clip the article when he was appointed and it looked like we were going to get some pretty good action, but the article went on quoting a legislative consultant that said, "They really don't have much power anymore." Well, if they don't, that's a problem for the Legislature.

But here we have "Psychiatric Dispute Overlinked Between Brain Drugs and Violence." This is the Sunday Examiner and Chronicle, June 10, 1984. It's interesting because - and your consultants or members of the Legislature might want to look into it - because, "If further studies confirm the theory it could have enormous implications because of a national trend toward releasing mental patients quickly from mental hospitals. The average day in most psychiatric hospitals is less than two weeks since Wyatt. And patients at Napa State Hospital, for instance, are drugged to the day of release," according to Napa psychiatrist, Dr. William Schwartzman. "The release patients are supposed to continue their medications as out-patients at community institutions but many don't and swiftly lose the therapeutic value of the drugs," and so forth.

"The Issue is Hot." Here it is. Here's the Sacramento Union, May 7, in which they talk about street people. Dr. George Tarjan. This is from Los Angeles, Mr. Tucker, from your area. They're quoting UPI and it says, "Dr. Tarjan said that," - 11,000 participants at the 137th annual meeting and they're talking - "we must develop support and treatment facilities in the community for the patients that are released." The same thing in the San Francisco Chronicle, May 8. Here's an article from the Sacramento Union. "Some Social Security Checks May be Sent to Soup Kitchens." "Patients that get lost," said Margaret Hector, Secretary of Health and Human Services. This situation is absolutely incredible!

Here's one from the Sacramento Bee, September 29. "Father Files Lawsuit in Jail Assault on Retarded Son." It's being bought by an attorney by the name of Joseph Babich, and I guess that's the Joseph Babich that used to be in the Governor's office, then was a superior court judge. Mixed up--isolated at first and mixed up with other patients that abused him.

I gave a talk in June to a group, the local mental health directors and a group of volunteers in Sacramento, and I said that volunteerism is an absolute must. Whether we like it or not, the state and the federal government cannot do all the things we'd like



them to do for the developmentally disabled and for the mentally ill and we need volunteers. That's why James McDowell is here. He's the best volunteer I've ever met in my life, and he probably knows as much about the field of mental health as anybody I know, and is the father of a son who was a patient or a client in the Stockton State Hospital. And he is the chairman of our board of directors of a corporation that we formed in 1975 and has started programs throughout the state. When you visit your local bookstore and giftshop here in the Capitol, you're buying artifacts that are being made by our students and they are paid for making these artifacts. It's part of the treatment program. These are things under the guidance of people, volunteers such as James McDowell, a local insurance man, third generation Sacramentan, is being done who probably devotes half his time, the kind of help that you need.

I took the liberty of calling Senator Wadie Deddeh about the problem after meeting-- the third meeting I had at the Department of Mental Health - if that's the term, the name of the organization - in which they were talking about people getting lost and not getting treatment. And I pointed out that this alliance - I think the lady who's president of one of the volunteer's group is from La Mesa in San Diego County. Of course, Senator, I think you were mayor of one of the communities in the Mesa and I read this in the handbook this morning, and that you also had something to do with special education. So you have a special feeling and a special expertise. Of course, Mr. Bronzan is a former supervisor, knows what the problem is at the county level.

Helen Teisher, and I think I recognized her in the audience - I haven't met her personally - I think she is here today. I discussed the matter with Senator Deddeh and asked him if it would be all right to send out a letter but work with his office on the letter, and this we have done. The letter went out Friday. I gave a copy to the people at the Department of Mental Health and requested that they give it to the director so he would know where we're going, and a copy was delivered to Mr. Bronzan's office. I don't know whether you've seen it or not yet, Senator, because it went out in the mail, it went to your district. So I'm sure that many of them haven't received it as yet. But it expresses my feelings and Senator Deddeh's feelings, and if I may, I'd like to read this and turn it over to Mr. McDowell for a few brief remarks because he has some feelings on this subject. But very briefly, I'm very happy you're doing this. In many instances it's extremely difficult to get people into the state hospital that should be in there, that they're in there for such a brief amount of--a period of time that there isn't enough time to identify their problems, and if they're eligible for Social Security or other benefits, to make sure that an application is made so that they get it and it follows him or her after they're released from the state hospital. I am concerned in the news when they state that 800 plus developmentally disabled are going to be released from the state hospital system and I'm quite sure that there are insufficient homecare facilities to take them.

And the letter says, "Dear George," - addressed to Governor Deukmejian. You can see it's a friendly bipartisan letter, members of the committee. "A grievous situation faces our state administration, the Legislature. It is the unhappy plight of the homeless mentally ill. I can't emphasize too strongly that this is not a partisan issue but a problem the legislators of good will of both parties will wish to address at this forthcoming session of the Legislature. California has been the leader in enlightened and effective legislation for the mentally ill and those with developmental disabilities. What we now accomplish can have a profound influence nationally for this is not a local issue but one of endemic national scope.

"The enclosed article from the San Francisco Chronicle," and it's appendent to this, Mr. Chairman, and I'll leave a copy with you, "sets forth the concern of a special task force of the American Psychiatric Association. While the report of this task force is not yet ready for distribution, their recommendatios have been printed and I enclose a copy.

"The statistics in California are admittedly guesswork, but the Community Mental Health Division of the Department of Mental Hygiene sets the number of homeless in California between 50,000 to 70,000, of which the number of chronically ill are as high as 37,500. They estimate that the number of chronically ill in the state is 170,000. This division says that of 44,000 jail inmates 16 percent or 7,000 are estimated to be seriously mentally ill, and many of these are mercy bookings. The American Psychiatric Association says that to address the problem of the homeless mentally ill we must begin with provisions for meeting their basic needs of food, shelter and clothing. They further recommend an adequate number of graded (step-wise) supervised community housing settings. I strongly agree with these recommendations and hope that you share my feeling.

"There are a number of organizations that are in a good position to provide information about the homeless mentally ill. The League of California Cities and the County Supervisors Association should have information on arrest and jail commitments of the mentally ill, as well as information from their welfare departments and hospital facilities on who might be mentally ill and homeless.

I'm sending this letter to various state agencies and asking their cooperation in providing what information they may have and solicit suggestions on how to ascertain this information. I will keep you informed as to their replies and cooperation.

"I am pleased to note that there is an Assembly committee that has been actively considering the problem of the mentally ill." And, of course, excuse me, Senator, and the Senate committee. "I commend them for the work and would particularly appreciate their interest in this problem. This is not a situation that can be wholly solved by providing counties with block grants, but needs the guidance and assistance of the state to provide an equitable and uniform program for the entire state.

"I would appreciate your answer and I'm ready to assist you in any way I can. I

would appreciate your consideration of this problem when considering the budget. Respectfully and cordially." And it lists the various state organizations, Mr. Chairman, that the letter went to, the last of course, by far not the least, all members of the Legislature. I'd like to leave this with you because it has the Chronicle article and it also has the recommendations of the American Psychiatric Association. Their report at this time has not as yet been printed. And I'll slow down if you want to hand that to the Chairman. Thank you.

Mr. Chairman, here's the letter from the Citizens Action League for Mental Health. I'm sure they're going to be testifying but this is a volunteer group, the kind of people we need to bring the problems to our attention and also, of course, to help lobby good meaningful legislation to relieve the situation.

I'd like to introduce James McDowell. I noticed in the handbook that Mr. Tucker had gone to college in Italy. I was going to tell him that James McDowell was a machine gunner in Italy. I give you James McDowell.

MR. JAMES MCDOWELL: I'll be very brief. My background is primarily in developmental disabilities but it's a very good perspective to view the sister service system. I feel that the mental health system suffers from three distinct but very closely related defects. One defect is that the power structure is the providers. The power structure of mental health is the psychiatrist-related professionals and the hospitals. They, in my view, roll the system and whereas developmental disabilities is primarily a consumer directed system, though it has to struggle with bureaucracy like anywhere else.

The other defect is the one that you're specifically addressing in these hearings and that is the issue of rights. In my humble view from watching a number of people who have impacted your system, the rights are so strictly constructed as to serve as an effective barrier to prevent people from obtaining needed services. And then in the case of too many of the professional providers, there is almost an enjoyment of this denial as one more person turned away. The rights are also such that a revolving door is created, that the person enters the system, funds are expended upon the person and then they're immediately turned loose to encounter further personal peril or to just keep coming back through. The thing lacks integration.

Money is desperately needed in the system but the mere dumping of money into the system is just going to be more waste unless the money is integrated to accomplish missions. There is a tremendous amount of work to do and I think it starts right at the rights. I believe that the first right that the mentally ill person has is not that he can refuse services, but that help can be and will be and must be offered and accepted.

I appreciate, Alan, your inviting me to come. They appreciate my being brief.

CHAIRMAN MCCORQUODALE: Thank you, Senator Short and Mr. McDowell. We appreciate your telling and setting the stage for our hearing today and to give us a perspective from your view.

SENATOR SHORT: Mr. Chairman, I think I speak for everyone in this room that we appreciate your attention to this problem. And while it may not have the glamour or the campaign contributions that other fields of endeavor have, let me tell you this. In the five times that I ran for the Senate, my constituents, both parties, liked the fact that I did this and the longer I was in the Senate the more naughty things I guess I did, and everytime I ran they kept pointing out terrible things about me and unfortunately some of them were true, Mr. Chairman. But, I never had a more loyal group of people supporting me than those people with a handicapped person in their household. And Mr. Chairman and Mr. Bronzan, that's one out of every four families. Thank you very much.

CHAIRMAN MCCORQUODALE: Thank you. Now we'll have Carl Elder and Barbara Lurie.

MR. CARL ELDER: Thank you very much. I want to tell both committees and their staff how much I appreciate the opportunity to give a very brief overview of what the Lanterman-Petris-Short Act currently endeavors. And I notice you have a very distinguished group of panels, members on the panels, to discuss some of their experiences and concerns and for that reason I will keep this extremely brief.

As we know, the Lanterman-Petris-Short Act was first enacted in 1967. Its operativeness was delayed until July 1, 1969. I think when one looks through the Lanterman-Petris-Short Act one can understand why many of the provisions are as they are when you look at the basic intent that was behind the Act, and I'll just read off four of the express legislative purposes for enacting the LPS Act. One of them was to end the inappropriate and indefinite commitment of mentally disordered persons and eliminate legal disabilities. Another was to provide prompt evaluation and treatment of persons with serious mental disorders. Another was to guarantee and protect public safety. And a fourth purpose was to safeguard individual rights through judicial review. And I think all the periods of detention in the Act reflect those basic purposes as well as others.

The central feature of the Lanterman-Petris-Short Act is the provision of mechanisms for a limited and voluntary detention of mentally disordered persons for the purposes of evaluation and treatment, while at the same time providing these persons with enumerated rights and procedural safeguards. The detention mechanisms contained in the LPS Act are arranged in a progressive series of steps or stages with each subsequent stage generally providing for increasingly longer periods of possible detention, but imposing increasingly stringent procedural requirements.

And I'll turn just briefly to a very brief discussion of each one of the basic periods of detention. The 72-hour period for evaluation and treatment. A person who as a result of mental disorder is a danger to others or to himself or herself or greatly disabled as defined - and that definition's very important - may be taken and placed in a facility designated by the county for evaluation and treatment for not more than 72 hours. The person initiating this process may be a peace officer, member of the attending staff of an evaluation facility, or other designated professional person. I believe

there's also provision made for members of crisis teams in addition to those. An application in writing by the initiating person is required stating that the initiating person has probable cause to believe that the person meets the criteria for 72-hour detention and setting forth the description of the circumstances giving rise to such probable cause. No express provision is made for administrative judicial review during this 72-hour period.

Before the end of that 72-hour period or at the end of it, if a person being detained, if the treating staff determine that they continue to meet the criteria, that is as a result of a mental disorder, they are a danger to themselves or others, or gravely disabled, they may be certified for not more than 14 days of intensive treatment. The certification is made by two professional staff of the evaluation facility if they have found that the person meets the commitment criteria and the person has been advised of the need for but has not been willing or able to accept treatment on a voluntary basis.

An automatic administrative review hearing of the certification is required within 7 days of the initial detention unless the person requests a judicial review. And that was as a result of the Doe v. Gallinot case. In addition, specific provision is made for judicial review by habeas corpus, so that is before a superior court.

There's an additional period of 14-day intensive treatment available for those who are suicidal, but other than that the next period of detention - and I'll just discuss this very briefly - is the 180-day post-certification for persons who are a demonstrated danger to others. And so at this point we see how the Act more or less splits off. If you're a danger of--eminent danger - in fact, the term is no longer eminent - a demonstrated danger to others, when you leave the 14-day period you have available a 180-day period if you meet the criteria. There's specified conduct that must have been engaged in and you must present a demonstrated danger and it requires a filing with the court and a full judicial hearing on whether or not the person meets that criteria. And if they do, if they're a demonstrated danger to others, they may be detained for up to 180 days, and at the end of that period, if they continue to meet that criteria, the detention period can be renewed.

ASSEMBLYMAN BRUCE BRONZAN: Is that hearing held in superior court as well?

MR. ELDER: Yes it is.

ASSEMBLYMAN BRONZAN: Similar to the other - the first time?

MR. ELDER: Right. Similar to the petition for habeas corpus.

ASSEMBLYMAN BRONZAN: Who represents the consumer here? The public defender most of the of the time?

MR. ELDER: Generally it would be the public defender or a private counsel, and either the district attorney or the county counsel of the board of supervisors so designated represents the people.

ASSEMBLYMAN BRONZAN: Just very quickly. The person who is defended by a public

defender, they can bring, if they wish, testimony from a different psychiatrist or psychologist or professional about the state of that person?

MR. ELDER: Yes, they have a right to put on expert testimony.

ASSEMBLYMAN BRONZAN: Is it generally the case that they don't because the cost of doing that would have to come out of the public defender's office and it's simply not provided for? Is that normally the case?

MR. ELDER: I really can't speak to that.

ASSEMBLYMAN BRONZAN: I'll ask somebody else then.

MR. ELDER: So we have the periods of time - the 72-hour, the 14-day period - and then it's where the Act begins to split off and offer different options. As I say for those who are suicidal, there's a second 14-day period; for those who are demonstratively dangerous there's this 180-day period; but perhaps, and I hesitate to say the most important period, but certainly one of the most significant periods of detention is the conservatorship process which is available for only those who are as a result of a mental disorder greatly disabled. And as I say, that is available for persons who are found to be gravely disabled as a result of a mental disorder. The proceedings for conservatorship are initiated by the county of residence and a detailed conservatorship investigation containing specified information is required. A court hearing or trial is also required. Provision is made for establishing a temporary conservatorship lasting no more than 30 days except when a jury trial is requested, pending final court disposition on the conservatorship proceedings. The conservatorship can last no more than one year, although subsequent conservatorships can be established using the same procedures. And I've attached also a copy of the provisions of I believe it's Section 5008 that define various terms in the LPS Act, and you'll note that under conservatorship there's three types of conservatorships, three definitions that are there. There's the standard definition and then there's one for what is often referred to, and you'll probably hear this term, Murphy conservatees. Those are those who are incompetent to stand trial and it's available in those limited circumstances for those folks. And then gravely disabled is defined specifically for minors also. It's a different definition. And the definition, I think you'll probably have testimony today, some that believe that it probably should be revised or some that probably think it's adequate and what have you. An extremely important concept - how you define grave disability for the purposes of all these detention provisions.

Just briefly, the LPS Act, in addition to the periods of detention, also contains very specific enumerated patients' rights. There are specific provisions on confidentiality of records and numerous other related provisions. For example, on the administration of ECT there's a very detailed statutory procedure establishing the procedures that must be gone through before ECT can be administered.

Turning briefly to recent developments, I think as your staff has indicated to you, the Act really has not undergone a great deal of revision since its first enactment.



Probably the only two areas that really have been major endeavors have been the demonstratively dangerous period, the 180-day (inaudible) was substantially revised several years ago to change the period from 90 to 180 days, and to change from the term eminently dangerous to demonstratively dangerous and make certain other revisions.

The other major area in which the LPS Act has been revised is the codification of the court's holding in Doe v. Gallinot, the federal court that said that those who are gravely disabled must have a state initiated review within seven days of initial detention and that's in addition to the provisions for habeas corpus during that 14-day period that can be filed with the superior court.

Briefly, I do have the 1982-83 statistics. I'm told that the 1983-84 statistics will be out very soon, so just let me give you real quickly the number of detentions that occurred under each of these mechanisms. There were during the '82-83 Fiscal Year 71,650 detentions for 72-hour evaluation and treatment. During the '82-83 Fiscal Year there were 30,467 certifications for 14-days intensive treatment. During the 1982-83 Fiscal Year, and this is when it was a 90-day post-certification period for eminently dangerous, there were 196 detentions. And during that same period .....

ASSEMBLYMAN BRONZAN: 196 statewide?

MR. ELDER: Yes. That's statewide. 196. Relatively small.

ASSEMBLYMAN BRONZAN: Not 196 total.

MR. ELDER: 196 total. And that is--I'll just briefly indicate one of the reasons that--that's correct. It was a very small amount because the standard of proof was very difficult when it was eminently dangerous. In fact, that prompted the revision of that several years ago by then Assemblyman Stirling, Dave Stirling, and changed the period to 180 days, changed it to demonstratively dangerous and we're not really sure until I get the new statistics what type of increase we're going to see in that. I'll just note parenthetically that the concept of demonstratively dangerous was judicially challenged and a California court of appeals upheld it as being constitutionally adequate.

ASSEMBLYMAN BRONZAN: What's the difference in the definition of eminent and demonstrative? I don't know that.

MR. ELDER: Well, without taking a long time, I think perhaps I could provide you, your staff or you, the court very carefully--you know, you do have certain constitutional requirements. The difference may be more apparent than real. So I'll leave it at that and provide your staff, and that's one thing I want to indicate, I'll provide you or your staff with any information I can on the case law and what I have on the particular issues here.

On conservatorships, for temporary conservatorships during the 1982-83 Fiscal Year there were 8,750. And for permanent conservatorships during that period there were 11,790.

And I think the last thing I would comment on when we talk about recent changes, and I note it's in your staff's work and I believe some of the folks testifying today will

be alluding to it, one important case that is being dealt with by the Department of Mental Health now and perhaps it will have to be dealt with by the communities (inaudible) is the Jamison case which in essence involves the rights of patients to refuse medication under certain circumstances.

ASSEMBLYMAN BRONZAN: Question. I've heard in the rumor mill that the Department is contemplating changing the LPS regulations. Can you shed any light about what's being considered?

MR. ELDER: The Department currently has under review and consideration a revision of the patients' rights regulations. They're going through the administrative procedure process. If we're talking about the Jamison type of thing, the right to refuse, there's already in Title IX the regulations relating to voluntary patients. There are no regulations adopted relating to involuntary patients. The Department is at Napa State Hospital implementing a consent to create--the Department entered into with the plaintiffs and we anticipate that at the end of approximately a one-year period, which would be April, that the procedures will be applied to other state hospitals that have those same types of patients. So there is activity afoot on patients' rights regulations.

ASSEMBLYMAN BRONZAN: And that's all that you're aware of?

MR. ELDER: We also have ECT regulations that are being promulgated. They're going through the administrative procedure process.

ASSEMBLYMAN BRONZAN: Lastly, for me, does the definition of grave disability change per level of hold - for 72-hour to 14-day to .....

MR. ELDER: No, it remains the same. It's a constant.

ASSEMBLYMAN BRONZAN: The same legal attest at that court hearing?

MR. ELDER: That's correct.

CHAIRMAN MCCORQUODALE: We've now been joined by Assemblyperson Mojonnier from San Diego County. Do you have any questions at this time? All right. We'll go to Ms. Lurie then.

MS. BARBARA LURIE: Good morning, and thank you for inviting me. My job today is to give you some of the philosophy and the perspective of the Lanterman-Petris-Short Act, otherwise known as LPS.

The first thing you should know is that this law wasn't created because some bureaucrat had nothing to do on a boring Monday afternoon. It was a reaction against some very real abuses that went on in the past, and perhaps LPS is more understandable, even more palatable, if viewed in the context of what proceeded it.

Before it was passed there were vague indefinite standards of who could be put in the hospital involuntarily and for how long. The old criteria stated that, "If a person were in such overall mental condition," - by the way, the term "mental condition" was never defined - "that they were in need of supervision, treatment, care or restraint, the person could be hospitalized until someone decided that they didn't need to be hospitalized

anymore." In other words, indefinitely. And that kind of elastic standard invited abuse and there was a lot of it.

The California Assembly Subcommittee on Mental Health investigated the mental health system and produced a report that Senator Short just referred to just prior to the passage of LPS, and in their research they found that the average commitment hearing lasted an average of 4.7 minutes and fully a third of them lasted less than 2 minutes. So someone could be put away, and I'm not talking here just weeks and days as it is now, I'm talking sometimes these commitments were measured in terms of years and decades. Someone could be put away for a whole decade on the basis of a 4½ minute hearing. And less than 30 percent of these people even had legal counsel when they had their hearings. People kind of went into the system and just sort of disappeared. And patients in those days often left their rights at the doors of the psychiatric facilities. There were no phone calls, no visitors in many instances, and very little in the way of informed consent.

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Here in California we had Dr. Walter Freeman in the 1940s and '50s who was doing assemblyline lobotomies, sometimes 25 a day, by inserting a knitting needle in the eye orbit and poking around and severing connections in the brain tissue.

At any rate, LPS came along as an attempt to balance the rights of the individual against the rights of society. It puts strict limits, as Carl Elder mentioned, about who can be put in the hospital now against their will and for how long. It was a revolutionary law in its time but as the years went by it's become the model for virtually every state in the Union.

If you look at the law in its full context, you'll see that it attempts a three-way marriage between treatment needs on one hand, the need of the public for protection and individual civil liberty needs. Some people think that this is a marriage that's now ripe for divorce, or at least a trial separation. That's probably one of the reasons for the hearing today.

The LPS Act tries to bow somewhat to each of these competing interests. The professional person gets to treat patients even if they don't want to be treated. That's a lot more than doctors treating medical conditions can do. But the professionals don't get carte blanche. The patients may be kept against their will but they're guaranteed certain rights, such as a right to a hearing, as Carl Elder mentioned.

So this medical legal partnership that LPS creates, that it forges these two arenas, is an uneasy one to be sure. It probably has something in it for everybody and it has something in it that's aggravating everybody. Family members, for example, as you heard the gentleman speak earlier, are very frustrated in trying to get their loved ones into the system. Both family members and clinicians are frustrated in trying to keep the patients in this system, and clinicians are very frustrated in trying to give treatment while they're busy hopping around all the legalities that are strewn in their path.

Well-meaning therapists are torn between doing what seems to make sense in terms of treatment and doing what the law requires. And society as a whole is frustrated at the barricades it sees in trying to get the mentally disordered off the streets, because they, unfortunately and erroneously, equate mental disorder with dangerousness. As an aside, I should mention that the mentally disordered are far more likely to be victims of crime than perpetrators. Studies have repeatedly shown that the mentally disordered as a group are no more menacing than the population as a whole. And finally, the patients themselves are frustrated. Our office gets calls everyday from patients frustrated because they want to get out and they can't. Or they want to get off their medication because they don't like the side effects and the law doesn't allow them to.

So, as you'll learn today, I'm sure that LPS has something--or it seems like at times it pleases none of the people all of the time, or all of the people none of the time. The frustration that it engenders may be an indication of its failure, but paradoxically it may be an indication of its success because the frustration seems to come equally from every corridor. And with any good compromise, none of the parties walks away perfectly happy. Everybody's displeased or disgruntled about what they've given up.

LPS can be seen as a funnel with a series of filters. It's fairly open at the top and then it starts to get narrower as you progress. So the longer someone is held involuntarily, the more difficult it gets to keep them. There's more stringent standards, more due process procedures. And it's intended that way. It's deliberate to filter out all but the most necessary, most severe cases. And it's also designed to screen out all patients who can possibly accept treatment voluntarily. According to its legislative intent, LPS favors voluntary treatment over involuntary. So obviously do patients and so does the therapeutic community. Voluntary treatment certainly is easier and more therapeutic. That's one point I think that all sides can agree on. No one really likes an involuntary system.

Many clinicians complain about all the legal rigamarole that LPS dumps on their lap and I'm sure you'll hear about that more today. Involuntary patients have a probable cause hearing and they're entitled to a second writ of habeas corpus hearing if they choose. Clinicians complain that they spend time that they could be treating patients in the courtroom, and I am sympathetic to that. But compare our mental health system to the criminal justice system. To hold a person in that system just for a few days there must be an arrest, a booking, an arraignment hearing with witnesses, subpoenas, pre-trial motions, and that's all before the trial even begins. And in that system, the person is usually free out on bail during all this legal maneuvering - patients are not. Further, the people who enjoy all these legal safeguards in the criminal justice system usually have committed a crime. Psychiatric patients haven't.

LPS in building legal safeguards for its patient is simply acknowledging that

whenever there's a concentration of power in any group of people or any person, be it the President of the United States, psychiatrists or whomever, there needs to be a checks and balance system to make sure that that power is not used excessively or inappropriately. And the ability to deprive someone of their right to freedom and liberty just on the basis of your signature as the law allows mental health professions to do now, is about as powerful as you can get.

LPS also acknowledges the need for treatment. One of its goals, as Carl Elder mentioned, as stated in the legislative intent, is to "provide for prompt evaluation and treatment for persons with serious mental disorders." The law says that involuntary patients must be given treatment for the full period of time they're held. In other words, the law is saying if you're going to take away somebody's freedom, something that important, you darn well better give them something very important in return. Ironically, in pre-LPS days patients were put away because they were in need of treatment but then often didn't get any or got very little.

But in recognizing the need for treatment, LPS also recognizes that psychiatry is an inexact science and well-meaning professionals are apt to make mistakes. One of LPS's stated goals, as Carl Elder mentioned, was to end inappropriate commitment. That's why the criteria of LPS focuses on observable behavior rather than psychodynamics. In specifying that a person has to be a danger to themselves, a danger to others, or gravely disabled, the Legislature was saying they really don't care about the person's delusions, their hallucinations, even their thought process. What they care about is the person's actions and specifically the dangerous repercussions of those actions. Is this person likely to harm themselves, harm somebody else or are they just not going to make it without some kind of government intervention. Those three criteria were the only ones that were thought of as being so crucial that they superseded that individual's right to liberty.

Getting back to the possibility of mistakes, there's always a tendency for therapists to err on the side of caution and hospitalize a patient when there is any doubt. If a dangerous patient is erroneously released to the streets there may be screaming headlines the next day, there may be lawsuits, there may be a lot of repercussions, but there usually are no such repercussions if a non-dangerous patient is erroneously put in the hospital, except of course for the patient himself.

Another stated goal of LPS is to end indefinite involuntary commitment. Not only did long commitments unnecessarily deprive people of their freedom, but they created the institutionalized patient who spent his days and nights vegetating in the back wards of psychiatric hospitals. Getting well requires the opportunity to adopt to a reality outside the confines of the hospital and these people never got that opportunity so they never did get well. It was kind of a self-perpetuating situation, an iatrogenic disorder as Senator Short referred to.

Of course, LPS was predicated on the assumption that once the patient was released from the hospital there would be a whole safety net of community services and resources to rise up to meet him. These services by and large have never materialized and patients have gone from the back wards of hospitals to the back streets with very little or nothing inbetween. Some of the failures that are laid at the door of the LPS Act are really attributable to the fact that the money never did follow the patients in the community as was originally hoped and planned.

In sum, if any one system is to wed the conflicting medical objectives of treating sick people without legal delays, and the equally valid legal aim of ensuring that persons are not deprived of their liberties without due process, there's going to be some tension, both internal and external - that's inevitable - and perhaps that's not unhealthy. Many people who have watched the perverbial pendulum swing in the direction of patients' rights and due process are eager now for gravity to take its course. They want to see some swinging in the other direction. But on the other hand there are many people out there who think that LPS hasn't gone far enough in protecting the rights of patients. What makes it especially difficult for you as legislators is that one system, be it LPS or something new that you create, is going to have to accommodate all of the different sometimes competing interests, and it's not an issue of right and wrong really, but of different concepts of what is right. Every group, the parents, the patients, the advocates, the professionals, every group wants to see what's right and best for the patients, and LPS has tried to strike an artful balance among all these groups where perhaps none is possible. Thank you.

CHAIRMAN MCCORQUODALE: Thank you. You commented an interesting comparison between what doctors can do and psychiatrists but it seems to me that if it were that easy that we might not have to have a hearing. Often when the--what the doctor wants to do, a physician wants to do to a patient, the patient still has the ability to make rational - at least what we would term rational - decisions related to their care. And if they have blood poisoning in their hand they can decide whether they want to be treated for it and how they want to be treated. But we don't have the ability to let the body make the decision for the brain in a reverse situation. And for the person whose son comes home after being gone for three or four years and will only eat out of the garbage can in the backyard and sleeps in the rain and runs the risk of catching pneumonia or some illness and has no way to handle that situation, no way to take care of--make a change in the person's behavior, it's harder to discuss with them then the rational reason behind the Lanterman-Petris-Short Act of protecting the right of people to not be incarcerated or hospitalized against their will. It's not quite as easy as comparing the doctor and the psychiatrist.

MS. LURIE: That's correct, you're correct, but two points. One is that consents are not generally an all or nothing thing. Somebody can be mentally disordered but they



still may have the capacity to decide whether or not they want a particular medication, whether it makes them drowsy, whether it's unpleasant for them, what the repercussions of the medication are. They may have hallucinations and delusions in other areas but maybe they can make that one kind of informed choice. That's number one. And number two is that LPS does build in mechanisms to handle cases that you're talking about. If patients can't provide for their own food, clothing and shelter they can be hospitalized even if they don't want to be in the hospital.

CHAIRMAN MCCORQUODALE: Well, not very easy under the current court rulings, though.

MS. LURIE: Not very easily but it's done all the time. It was done to 11,790 people, according to Carl Elder, put on conservatorship last year.

CHAIRMAN MCCORQUODALE: Okay, any other questions?

ASSEMBLYMAN BRONZAN: I have one. I think you did a good job trying to demonstrate the various sides of the issue and also presenting the need to have some sort of structure and mechanism to protect the rights and you did a good job of that. I would say, though, that the reason we're having the hearing and the reason it's an issue now is it's from a different set of circumstances that caused the LPS Act to be passed in the first place. There was a whole background that you articulated well that caused, thank goodness, the LPS Act to come into being. But now there's a different set of concerns and emotions out there that are causing a reevaluation and that is--the simple way of explaining it is that there's a gigantic overwhelming under-attention to people who are sick, and the legal aspect of keeping people who are sick from being treated is just one of the ways, the lack of money, the lack of community programs, the lack of state. The whole system is meeting a tiny fraction of people who really need help. Only a small fraction are getting help. So that is the arena, or the aura with which we're approaching this. And what we have heard in the Select Committee over and over and over again are the problems of people who desperately need help, who can't because of the LPS Act. And where we hear that most is with children. Not that they are numerically more but that the problems of the LPS Act, it's vagueness and lack of specificity for the differences between children and adults, keeps kids from getting help. It's easier to put a child into the criminal system and into jail than it is to have them get treatment because of LPS, so tell us parent after parent after parent after parent. Now, clearly this balance that you refer to is something that has to be struck and the patient rights is one of the things that distinguishes us from less civilized societies and we have to keep that. But I guess this long preface is a question to you. In light of the fact that you are charged - and I respect your charge with the responsibility of heading up the patients' rights side of the system - but within that position do you see any problems? I mean, from your point of view do you see problems where the LPS Act goes too far? Do you see any problems particularly in the area of children?

MS. LURIE: Well, with regard to children there's a distinct problem in that the California Supreme Court in 1977 passed this ruling called Roger S. that required a precommitment hearing for kids 14 and over before they could be put in the hospital. The problem with Roger S. is that they failed to really clearly define what the purview was so that facilities out there don't know if it applies just to state hospitals, as a footnote seems to indicate, or all public facilities, and what about equal protection under the law, does it apply to all facilities? Because of the ensuing confusion around this Roger S., nobody seems to know how to commit their kids to psychiatric institutions. I and several other people worked with Senator Sieroty on passing legislation to spell out the nuts and bolts of the Roger S. decision so once and for all that could be clarified, but that bill had a nice price tag on it, because we're talking about hearings, and it wasn't well received in some quarters and it died. But I do think that there's some kind of clear articulation that is needed around how you can hospitalize children, because of this ambiguity that Roger S. has brought on.

As far as the fault of the LPS Act in general, I truly think, as I alluded to earlier, that LPS was predicated on the assumption that there was going to be a gamut of community services, a continuum. Those with the most severe problems would end up institutionalized. Those with little less there'd maybe be day treatment centers. Those with a little less, (inaudible) cares, little less and so on. There's very little in the way of this continuum. It's more like a dichotomy, it's an all or nothing situation, and I don't know that that's the fault of LPS as much as that's the fault of the mental health system that didn't build the supports that were needed to buttress the LPS Act.

ASSEMBLYMAN BRONZAN: One other question. Is it difficult in Los Angeles County - that's where you work?

MS. LURIE: Yes.

ASSEMBLYMAN BRONZAN: ... to get conservatorship, in your opinion?

MS. LURIE: Well, it depends I guess on how you define "difficult." There has to be a court hearing, there has to be testimony; the patient is represented by a public defender. If the person generally has to be evaluated by a mental health professional at a designated facility, generally it would be good if they were hospitalized there. If that's what you define as difficult then it's difficult.

ASSEMBLYMAN BRONZAN: I'm talking about difficult if somebody who really needs that, is it hard to get, is there often a chance that they won't get it? And I specifically am raising the question because we met a young girl in our travels to Los Angeles in in-patient psychiatric, county, USC - a 5-year-old girl who was extremely suicidal and homicidal. Both parents were in jail for murder for the murder of her sister and they feared for the life of this child. The 72-hour had run up, they were at the end of the 14-day - they were at 12 - they were battling for conservatorship and didn't think they could get it. What they ended up getting was a temporary extension of the 14-day, and

I don't know exactly what the status of the child is right now, but they were absolutely certain that if they lost, the child would die, would destroy herself. And what they presented to us, and I'm just repeating to you what things we've heard, is that it was extremely difficult for them in cases like this to gain conservatorship.

MS. LURIE: Well, conservatorship is, as Carl Elder mentioned, just for people who are gravely disabled, unable to provide for food, clothing and shelter. That definition has been changed for children a couple of years ago because kids by definition are unable to provide for their own food, clothing, or shelter so how can you tell if one can't because of a mental disorder? So the law was rewritten to say that a gravely disabled child is one who can't avail himself of the food or clothing or shelter that's been provided for him or her.

Now, the judge in our county doesn't impose a middle-class guideline of providing food, clothing and shelter well, dressing well, eating a balanced meal, you know, living in a nice warm place. He's imposing minimal standards - can this person provide food or clothing or shelter on a minimal level, and if they can he will find that there is no grave disability. So if you think that's difficult that is the standard that he imposes. Some people are out there and they certainly live lives that you wouldn't want to live, that I wouldn't want to live. Their quality of life is very poor but they are to some minimal level providing for themselves - they do not want hospitalization - so the judge in our county allows them to continue what they're doing.

But getting back to kids, in our county right now kids can be hospitalized on parental signature in most private and county facilities because, again, of all of this unclarity around the Roger S. decision. Facilities have decided to just go ahead and do it until such time as they're told they can't. So that doesn't seem to be much problem. What is a problem is getting kids into state facilities because the states definitely are covered under Roger S.

CHAIRMAN MCCORQUODALE: All right, fine. Thank you. We appreciate your coming today. All right, we'll take a break now so the transcriptionist can take a break. Relax her fingers.

- BREAK -

CHAIRMAN MCCORQUODALE: All right, we'll resume the hearing. Mr. Bronzan, you had a comment you wanted to make?

ASSEMBLYMAN BRONZAN: Yes. During the break my staff gave me a report on the little girl that I mentioned that we discussed just at the end of the last witness and I thought I would give you the report as to what happened to her, or at least so far. First of all, it was determined, which is apparently part of the law and the practice, that the fact that she was extremely or severely homicidal and suicidal was not germane to the issue of whether she can be put on conservatorship. So the fact that she was very, very ill and dangerous to herself and others was not considered relative to whether she could

be put under conservatorship. Secondly, there is no legal way under LPS for a minor, somebody below seven, to voluntarily commit herself. So what happened is with this particular case, it turns out she, fortunately, got a very sensitive judge and the judge met with this girl privately in his chambers; and get this: the girl asked to be kept in treatment and told the judge that she felt it was good for her. So because of that voluntary statement to the judge, the judge ended up awarding her conservatorship which then provided a legal mechanism to involuntarily keep her. Follow what I'm saying? And now, if that isn't a hole in the system where you have to get a voluntary statement by a person under seven in order to get involuntary mechanism at play to get the person treated because they're severely homicidal and suicidal, if that's not a screw-up somewhere in our system, I don't know what is. And obviously the balance here--there's horror stories from putting somebody in the system that shouldn't be there, but my gosh, we have to figure out a way to protect people when they're really seriously hurt.

CHAIRMAN MCCORQUODALE: All right, thank you. Our next panelist is Marjorie Schwartz, American Civil Liberties Union. Why don't we have the whole panel come up. Is Colette Hughes here and Jean Matulis? Colette Hughes is with Title IX Patients' Rights Advocates, and Jean is with California Network of Mental Health Clients.

MS. MARJORIE SCHWARTZ: I'm Marjorie Schwartz representing the American Civil Liberties Union. I'd like to start by telling you a little bit about my background in this area. In law school I was a legal research assistant in a county public defender's office as a full-time job and I spent about a year-and-a-half representing LPS clients during that period of time. After that I went to work at the State Public Defender's Office and did lobbying for them, and during that period of time we were doing the Doe v. Gallinot suit and I was the lobbyist representing Doe on the implementation legislation. Coincidentally enough, I have now gone to work for the American Civil Liberties Union and while that--after going to work there I learned that we also are the counsel on Jamison v. Farabee. So I think that I have had some experience, although I did not have any direct involvement in Jamison other than helping us to get attorneys fees. I have had some experience with these issues, both from the legislative point of view and from the practical point of view.

Generally, our philosophy about civil - and I'm going to confine my statements to adults - I almost 100 percent concur on what Dave Meyer will say to you about children - and so I will primarily confine my statement to adults. Generally, our philosophy is that you have to be careful that people are not confined because of judgments over lifestyle. As much as it troubles people to see others who lead lifestyles in which they sleep in parks and go through garbage cans, we have to be careful that people who do that have a choice, a knowing choice, that that is the way they choose to lead their life. It does reach a point where people cannot make those decisions for themselves and at that point the state does have a right to intervene in the best interest of the person. But

it is extremely important that people be given as much freedom to make decisions about the control of their life as possible and that we not make decisions about confinement based on differences and judgments on lifestyle.

I will just go through some of these questions that have been sent to us and tell you what our response is briefly to some of them. As far as the 51/50 which is the procedure by which people are taken either from courts or by law enforcement to a mental health facility, my experience in Sacramento was confirmed by my discussion with the head of the Los Angeles Public Defender Mental Health Division, Ed Gilmore, who I spoke to last week. Both of us feel that there's no problem with the criteria. The problem is that there's a limit on facilities and resources. The people who are taken to the secure mental health facilities, who require extra amount of supervision, are rejected. They clearly meet the standard but there is a problem in security. Apparently it's been solved in Los Angeles by a psychiatric wing of 35 beds in the jail. However, that is, as far as I know, the only county that has that type of facility. And even from what I understand, that is not sufficiently large. I know that when the sheriff here, or the courts were sending them to the UC Medical Center, psychiatric wing, the most common complaint was, and there was actually blackmail, that we're going to send these people back until you provide us more sheriffs to guard them. And it was clear that the people met the standard. The only people that were retained were the most passive, people that could be put on drugs and needed very little supervision. And I lobbied for this when we were doing funding for the jails; unfortunately, I did not get any support. But I wanted that millions, hundreds of millions being given to the counties to be spent on jail construction to somehow be tied to additional facilities for the mentally ill. There are too many mentally ill in the jails, and the beds in the psychiatric facilities are not being properly used with people that don't belong in the criminal justice system. So I think again it's a question of dollars. It has nothing to do with changing the statute or the criteria but somehow the counties have to provide facilities where there's proper security for people who are mentally ill to such a degree that they are either active and wander away or try to injure other people.

On the second question, the temporary or permanent conservatorship, this a little bit relates to what Mr. Bronzan was saying about the 5-year-old girl, and there is some clarification that's necessary on that. The 72-hours is the same regardless of the standard - danger to other, danger to self or gravely disabled. Then you go into a 14-day hold. That's the same for either situation. Gravely disabled is the only one that goes into conservatorship. But danger to other and danger to self do have long-term holds. I don't remember the term on danger to self. I think it's still 90 days.

Recently, Senator Keene carried a piece of legislation, SB 236, that expanded the danger to others. And those are prosecuted by the district attorney. They're handled differently. But you can get a long-term hold on someone who's either danger to self or

danger to others. It's just not called a conservatorship and it is less than a year. But generally the procedures are the same. And often the complaints about not being able to hold these people, when you question further you find that they never even tried these alternative methods of holding people.

ASSEMBLYMAN BRONZAN: Is that method available for children?

MS. SCHWARTZ: I don't see why not. There's no reason why not. And I think that the rationale - again I want to confine this to adults - I think maybe in the case of a child that's suicidal you may be able to make an argument that it's different than an adult. But in the case of adults, people are verbally suicidal for years and it's often a way to get attention. And you can now under present law hold them for 31 days and plug them into a prevention type program. If a person who's suicidal will be benefited by that type of a program, you'll know within 31 days. And after that point they can become voluntary or you can extend the--if there's additional suicidal threats, you can keep extending the commitments. But the problem with suicidal is that it goes in and out, it isn't permanent like grave disability can be, and people can function for many years and maybe become depressed for a week or a month and then threaten to commit suicide. And so I think that there's a justification for not using the conservatorship where they permanently lose control of their life, their finances, where they live. Because the mental illness of suicide or the result of suicide is different and that is that day to day they can take care of their lives but maybe a crisis happens and the person can't deal with it and it just doesn't justify permanent loss of control.

The problem with danger to other is a little different and that is that the literature is replete with studies, and I think psychiatrists and psychologists will be the first to admit that they can't predict danger to others. There's a relatively famous study that was done in New York after a court decision released a number of people because the court felt that they were being held - they weren't seriously, mentally ill and they hadn't committed a crime and they were being confined on a dangerous type of standard that was overbroad and vague. And after there were--there were hundreds released and they compared the results of the release with their diagnosis and predictions and the psychiatrists were 90 percent false on their predictions. In either way, people who were predicted dangerous turned out not to be and people who were predicted not dangerous turned out to be.

And so, what you're doing, what the value decision we've made is that it's better to err on the side of the freedom in these cases, because there's just no way to know who is dangerous. Other studies show that the mentally ill are not dangerous at a higher percentage than people who are not diagnosed as mentally ill. And so, for that reason we've kept the danger to others standard quite narrow and we've limited the terms of commitment, again, less than a year, but it was just increased to six months.

The other change that was made in the Keene legislation is that it allows the



commitment to be made on the basis of a threat that was made prior to being locked up. Under previous law it had to be either an overt act or a threat while in a confined situation. It was felt that a threat made under those circumstances should be taken more seriously than threats like I'm going to kill that person - which people say in their ordinary course of living - I'm going to get that person or I'd like to wring his neck. Those kinds of statements are made and you have to be careful that those aren't used as the basis for loss of liberty. And we adamantly opposed that change and it only went into effect - I'm not sure whether it was this past January or the January before - but I would strongly advise that you take a look at the impact of that change and the increase in the length of commitment before making any further changes in this area. I think it would be interesting to see whether there's been an increase in commitment, whether one's that go to trial aren't successful and generally what has been the result of those changes before any further changes in that area.

I have to apologize on the incompetency issue - the medical procedures. I had hoped to speak to the lawyer, our lead lawyer, on Jamison - I think he's been on vacation and I haven't been able to reach him and I would not want to even address these without discussing with him. I would prefer sending these questions to him and having him submit some written testimony on Jamison. I had hoped to get him here. So I'm going to pass over (B) rather than talk about something I really don't know what I'm talking about.

In moving to (C), (C) talks about the option for recertification for a second 14-days now for suicidal and I think I've pretty much answered this actually about - oh no, I'm sorry, this is whether we should have second 40-days as a substitute for temporary. The general consensus of people I've talked to in the field, again, is that the T-con, there is some abuse already in the temporary conservatorship. It's often used to buy time. What happens is the guardian and the other people involved just haven't really had time to evaluate the patient and decide whether a conservatorship is appropriate or not. And that's a problem, but on the other hand we'd rather see a 30-day temporary conservatorship than an inappropriate conservatorship. You must keep in mind that there are various due process hearings that you have a right to during these, and that if you add a 14-day then the patient will have an additional hearing, a right to a new hearing, which I know the practitioners will oppose. And although we feel there's some abuse in temporary conservatorships that a great many of those that are filed do not result in permanent conservatorships, I think we prefer sticking with that rather than having either 14 days which might be too short or eliminating the temporary and going straight to conservatorship, because we think that the abuse will just move to permanent conservatorship which is a much more costly procedure and takes longer to sort out.

So I think if I can make that--I'm not sure I'm making this clear but the temporary is used to buy time for additional investigation, and although we think that's a little

bit abusive, we'd rather see that continue because the long-term result is that there's an appropriate and informed decision made about the person and we'd rather see that continue than new holds put in there that would just further aggravate the abuse or may not give the investigating authorities enough time.

And that really leads to the second problem and that is the caseloads on the conservators are just ridiculous. I think there were four conservators in Sacramento for 300 patients, 300 active cases. The conservator sees the person about once a year unless it's a problem case and there's some reason to bring it to their attention. The doctors, from our experience, there are some doctors that are doing it - I'm reluctant to criticize the medical profession, I don't think this happens in every case - but there really are some Medi-Cal mills on mental health doctors who ten-minute visits their caseload is entirely made up of SSI/SSP patients. I don't think that's always the case. Unfortunately, the better doctors are not willing to take Medi-Cal because of the low reimbursement rate or other problems, and I think that from my experience the doctors that were really helping people were in the minority. And also the caseload was just absurd. We found placement was made based on where there was an available bed, not what was the most appropriate placement for the person. It never fit the person, it was just where there was a bed open, and I think that that's one of the biggest problems.

This ties to another problem that I think runs throughout the system. As far as the statute, we don't feel there are any major changes that should be made in the procedure or the standard. I will be the first to admit that there is a great deal of ambiguity and probably a great deal of variance from county to county in the way it's being applied. The problem with trying to narrow that further is that you'll never have the special interests all agree, and I think to some degree the ambiguity has worked to the benefit of everyone. Counties have been able to work out a system that fits the county, fits the parties involved and fits the resources of the county. But I do think that there is a problem in terms of delivery of services and I don't know how else to solve it other than dollars.

The only other way I would suggest a change is that there should be some sort of more specific grant of denying rights on a conservatorship. And I think this might force the conservators to take a more individual look at each case. Right now they pay all the bills and they decide where the patient lives, and the patient is categorically denied any rights. There are some people that are in a more transition type of situation, and I think Barbara Lurie talked about this. This was the promise of this spectrum that was never delivered. And part of it is finances but I think part of it is inherent in the system because once a person is put on a conservatorship they have no decision-making rights over their life at all. I represented a woman who had been on a conservatorship as a result of a postpartem depression after the loss of a baby, and I hadn't seen her at the early stages and I have no doubt that she was gravely disabled. But by the time

she was up for renewal and I saw yer, she was living in one of the most more open of the community board and care facilities and really was, I would say, well or almost well. She had on her own gone out and got a waitressing job and was making some money and banking it, which she obviously would need to get back into society, because the \$300 or whatever it is you get a month is gone at the end of the month. When her conservator found out about that it jeopardized her eligibility - she was no longer totally disabled and she had to give up the job and she had to return all the money. So what would happen is once they decide she's well, she's out on the street, no job, no money saved and that's it. I saw that happen time and time again. I represented another patient who was in a VA hospital in Palo Alto, even though he was a Sacramento resident. He contested the renewal of the conservatorship. He won - the jury came back at 5:00 on a Friday that he was no longer gravely disabled. The conservatorship put him out on the street - they would not even send him back to the VA hospital until Monday morning to pick up what was left of his money and belongings - they would not cut a check until Monday morning when the office reopened. The judge loaned him the money to make it through the weekend, and I think that's why when you hear about the revolving door in the mental health system that's why.

I think that pretty much sums up what I wanted to say.

SENATOR MCCORQUODALE: All right, thank you. Any questions? All right. Colette Hughes?

MS. COLETTE HUGHES: I am proud to be representing Title IX Advocates and particularly look forward to participation in the task force. We're all participants who will share their own expertise and learn from the expertise of others in order to assist the Legislature to create the most dignified effective mental health system possible.

Since I represent the consensus perspective of Title IX Advocates, it is proper that all here comprehend the broad, diverse statewide constituency that is the Title IX Advocacy network by learning we are social workers, nurses, psychologists, paralegals, mental health administrators, ex-consumers, family members of consumers, attorneys, non-profit corporate community organizers, and some of us are even Republicans. By vocation we are patients' rights advocates. But the one characteristic we all possess is a shared value regarding our mission. Title IX Advocates seek to pursue the expressed desires of our clients within the confines of the law and to affirm the dignity of all individuals considered mentally disordered.

None of the important questions before us today can be probed in meaningful detail. That is the joint work of the committees, the task force, the Legislature and the citizenry at large. But I will briefly attempt to address a few of the great dignity and fairness questions posed in Section A, entitled "Involuntary Commitment Criteria," and in Section B, entitled "Concept of Competence Issues."

Title IX Advocates do not believe that Section 5150 sets forth meaningful,

evidentiary criteria for involuntarily detaining a citizen. We contend that the pre-1975 standard of reasonable cause based on belief related to personal observation is superior to the present probable cause and probable-cause-to-believe standard. Why? Basically for four reasons: Because no one, including hearing officers, knows what probable cause means within the LPS framework. More importantly, any cause standard to involuntarily detain should demand some basis in fact. The present evidentiary criteria permits reliance on infinite layers of hearsay, absent any demonstrable fact. The present standard requires the designated individual initiating the 5150 process to often substantially or totally rely on judgment exclusive from his or her own. This concern has been expressed to me several times by police officers in my own county.

The unfair and administratively cumbersome result is that the present standard often makes it impossible to determine the relevant facts and circumstances actually surrounding the 5150. This is the same information that is often used to justify the imposition of further involuntary detention pursuant to 5250. And therefore within 5250 hearings it is often very difficult, to impossible, for the hearing officers to determine whether or not there is any longer cause to hold, because it is nearly impossible to sift through what has been stated in the chart or elsewhere and to discover what facts, if any, are really there.

Title IX Advocates do believe that there is sound reasoning for continuing the differentiation between gravely disabled and danger to self. Why? Because the differentiation between the two categories or the substantiation of their co-existence focuses more specifically on the nature of both the legal and care or treatment issue involved than would the blending of the criteria. The statutory definition of grave disability should be modified to include the case law concept that a person is not gravely disabled if the person can elicit the assistance of willing and responsible others to help take care of his or her basic personal needs. Additionally, the need for shelter repeatedly arises as a discreet problem for individuals detained as gravely disabled. This is particularly true for those individuals considered chronic and not amenable to traditional psychiatric treatment. These individuals are usually diagnosed as having some form of schizophrenia.

Since the present model of treatment used almost universally throughout the system does not alter the chronic or psychlic nature of these individuals' problems of daily living, the focus should be on providing shelter - a safe homelike environment - rather than repeatedly thrusting unsuccessful treatment on individuals which only serves to frustrate treatment staff, and more importantly, unnecessarily assaults the dignity and often the physical and emotional health of these individuals categorized as chronic and not amenable to treatment.

Our obligation to ensure that these individuals' nutritional, shelter and clothing needs are met should not be equated with locked, in-patient custodial care as the sole

option, as it is no meaningful dignified option for these individuals at all. Nor is this option economically sound. Supervision, care, safety, nutritional needs and shelter can, for example, be fulfilled by living in a group home. Additionally, involuntarily hospitalized individuals often are not unable to provide for basic needs. Rather, frequently community-based support systems and programs either cannot, because there are not enough of them, or refuse to assist individuals in carrying out their daily living plans. Individuals have ended up LPS conserved as gravely disabled because some areas geographically in the State of California do not have enough P.O. boxes. Therefore, the individual cannot receive his or her disability check and is thereby rendered penniless. Or the individual cannot access entitlements because he or she has no legal address. The absurdity of such a tragedy is painfully obvious.

Looking at why danger to self should remain a separate category, some experts argue that in order to be held as a danger to self, intentional motive for self-destruction or an overt suicidal act must be shown. This argument is not substantiated by the experience of advocates and attorneys representing clients in probable cause hearings. The power of society to compel psychiatric treatment, including involuntary hospitalization, which is part and parcel of the LPS conservatorship rights disablement of the individual, would most likely be harmful to intentionally or unintentionally self-destructive and/or suicidal persons. There is no present evidence that society reduces suicide through involuntary hospitalization or forced treatment. In fact, of the few studies that have been done, the opposite has shown to be true. Further, it is hard to comprehend how depriving individuals, who already have low self-esteem, are feeling self-destructive or are suicidal, could receive a healing effect by virtue of rights disablement via the LPS conservatorship system.

I would now like to talk briefly about the issue of competence. The issue of competence is the greatest challenge we must now face if the system is to survive as a healing force. Historically, and under California law, competence or incompetence, capability or lack of capability to make a decision implicating fundamental human rights is properly determined in relation to the particular rights society seeks to disable an individual of. Incapacity is particular, not global. For example, a person may be capable of deciding whether or not to receive certain psychiatric treatment because he or she understands the risks and benefits inherent in such treatment, but incapable of entering into a business contract. Forcing treatment upon an individual absent of finding of incapacity to make a treatment decision is, in the opinion of most Title IX Advocates, tortious, unconstitutional, highly offensive to the personal autonomy of the individual, and counter therapeutic. The practice tears at the heart of the fundamental precepts underlying the medico-psychiatric healing relationship. Further, Advocates contend that those whose obligation it is to offer treatment should not determine whether or not a person is capable of making a particular treatment decision.

Psychiatric literature reflects the fact that the psychiatric profession is in accord that such a decision is a legal determination and not properly within the subject matter of medical judgment. However, unlike the Mills case model, Advocates do not endorse the proposition that probate judges are necessarily best suited to assess capacity or incapacity. Title IX Advocates do endorse the proposition of substitute decision-making once a determination of incapacity to make a treatment decision is reached. The substitute decision-maker should be a type of surrogate whose sole vested interest is to carry out the expressed wishes of the individual insofar as they can be ascertained if the person were presently capable to make the decision. The Advocates' position in this regard is that neither a conservator or a probate judge could properly function as a substitute decision-maker given the present manner in which the conservatorship system functions and is presently burdened.

Finally, as a matter of personal commentary, and this is a schtick that Assemblyman Bronzan has partially heard before, as has Miss North, but just as a stream can never rise higher than its source, nor can an advocate ever rise above the client, for the client defines our very existence. Likewise, no public official can rise higher than the citizenry, including those labeled "mentally disordered." The legal concept is called "equal protection of the laws" to which we are all entitled. Therefore, we must beware of the treachery inherent in judging those who appear or think differently from ourselves, judgments which obviously affect the quality of life of those individuals society considers mentally disordered.

In conclusion, I offer the following brief quote from Sir Thomas More, which talks about the concept of equal protection in relation to the rule of law. "The law...the law, I know what's legal, not what's right and I'll stick by what's legal. I'm not God. The currents and eddys of right and wrong which you find plain sailing I can't navigate. Yes, I'd give the devil the benefit of law for my own safety's sake."

Thank you.

SENATOR MCCORQUODALE: Thank you. I appreciate your quotes and especially about the citizens, although there are those who would look at the Legislature and say that the mentally disabled have more than their fair share of representation.

All right, our next speaker is Jean Matulis from the California Network of Mental Health Clients.

MS. JEAN MATULIS: Thank you. I'm very proud to represent the California Network of Mental Health Clients, and I am also a member.

I wanted to start out by commenting that it really says a lot about our mental health system if a person would rather eat out of a garbage can and stay in the rain than be a part of it. I think we have to look at what that says about our system.

The California Network of Mental Health Clients is a statewide self-help organization that's been in existence for--it's in its second year now and it's growing and it's



a real exciting movement and an exciting organization and it's comprised entirely of people who have been in the mental health system and we'd like to do something about taking control of our own lives.

One of the problems is the issue of forced treatment that we're here discussing today. Ultimately, the Network is against forced treatment, and in the meantime, seeks to promote all rights protecting patients who are in this situation. There are many problems with this. Forced treatment in itself is just not therapeutic. In order to have something that's going to be helpful to a person, I think most professional circles would agree requires a couple of key elements. One of them is trust and one of them is motivation. And in this context of forced treatment, these two things don't even have a chance to begin to develop. Many people would like, or would want some kind of help and are terrified of the mental health system because of what they themselves have experienced, what they have observed in their friends' lives and in people's lives around them. They go with their needs unmet. They're living in pain and they don't have anywhere to go.

Recently - well, not so recently - when the state hospitals started to move into the communities putting people out, it wasn't really out of care of the patients alone or necessarily, but it was really a primary--an economic motivation. But the funding never really did follow the patients as other people have pointed out today. It never really followed people into the communities. The programs that are the most vital to the patients, the most vital to their survival, are the ones that are constantly in threat of being defunded. They have to scrap. They live in constant fear of becoming defunded, the ones that are providing the most direct services. We're talking about homelessness as a criteria for an involuntary hold. Obviously, a person is actually within the definition - homelessness becomes part of the definition of mental disorder - and in a time like this when homelessness is obviously such a severe problem, to make that part of a definition, we really have to be very careful and look in the direction society is moving.

I know that--I've seen people like in the hospital that were--wanted to be there for--like they liked their counselor, they wanted to have the kind of services, discharge planning, that they needed and that they knew that they needed, but wanted to be voluntary patients. They were not allowed to be voluntary patients. They were made involuntary patients so that they couldn't refuse medications, and the rationale given by the doctor was that if they don't take medications, the utilization review team will come and push them out because they're not receiving medical services and we have no business keeping them here. Well, some of the hospitals take \$550 a day as a base rate for treating people and there is just no justification when this money could be going directly toward survival services. Why are people being medicalized? Why are their basic human problems being forced into a medical model just so it can be treated medically so that we can get the funding when it would be much more economically sound to fund direct survival service

programs? And this is something that we need and there's a growing number of consumer organizations which are now trying to get funding for their own programs because we feel that we know basically what we need, and we would like to see an end to the forced medicalization of people who are just simply trying to survive in this society.

Another issue that comes up is the standard for danger to others. Unfortunately, it is extremely vague. It's really sometimes at the discretion of people like a social worker, a nurse, that might feel that the person is dangerous. I've discussed this with some of these people before. I know of one woman who was brought in - she was calm when they went over - they had reason to look into the situation - the mother had wanted her to come in - the mother believed that they were going to come in as an intervention in a counseling team but they brought the police with them - and when the woman saw the police she became very frightened and started screaming and she was screaming and she was saying, "Please talk to me, please talk to me, I want to talk," because she felt she was going to be hauled off. Well, they didn't talk to her and the reason for not talking to her was because she was too upset to talk. By the time she got to the hospital she was so hysterical that she was thrown into a seclusion room and put into restraints. I am also an Advocate in the County of San Francisco and I had permission to read the records and when--the rationale was she wasn't hitting anybody at the time the determination was made - all she was screaming was, "I want to talk." And again, they found, oh, she was too upset to talk, so they put her in seclusion - and in the process of putting her in seclusion she was resisting this act and she struck out at someone. Well then, that was written down that she became combative while being assisted into the seclusion room. I always find it difficult to accept the double standard of the way these things are recorded that then become actually a legal document in the patient's record - they became combative while being assisted or while being escorted - and I never see the blow by blow description being given from a fair neutral party - it's very prejudiced - and then this is considered to be some sort of a medical document that has some sort of control over it and it's really shocking.

I have then seen patients being transferred to another hospital - after having an experience like that - one woman who was crying and put into seclusion and it said, again, became combative while being escorted. When she was transferred to another hospital the first words on her face sheet was this patient is combative. So originally she was crying and she was put in seclusion, but then because the seclusion experience was so provocative that then she was fighting back and this became the basis to hold her. Now she's branded as a combative person. So now when we get to the issue of observable - when we talk about 180-day post-certification, we're talking about observable violence - the violence that's being perpetuated upon the people is not being recorded in the way it's happening, yet the context is being changed so that it looks like this person is now observably violent whereas originally they were crying or upset. And I really find this

very difficult to handle.

ASSEMBLYMAN BRONZAN: Let me ask a question. On that particular case, was the violent - of course, it's impossible on a hearing like this to know what went on and what the truth was - but just as an example, to your knowledge, was the violence that the - was it a woman that you described?

MS. MATULIS: There was two women that I described.

ASSEMBLYMAN BRONZAN: Okay. Was that used subsequently in a hearing as you sort of alluded to? In that particular case, was that parituclar act of violence in resisting the escort, or whatever, used against them as part of the means to hold them for a longer period of time?

MS. MATULIS: Actually, in this case I don't know. However, what I'm saying .....

ASSEMBLYMAN BRONZAN: You're saying it as a general comment.

MS. MATULIS: In general, when you see--when I saw the face sheet on the next--see, she went from one hospital to another and I went to the next hospital because she had asked me to come in, and what I saw, it said the first thing on the face sheet was this patient is combative, this person is a danger to others and combative, but it didn't give the context. This person was combative while being hauled off, and I'm just saying that that wasn't spelled out, so it could have potentially been considered observable behavior that could be used against her.

ASSEMBLYMAN BRONZAN: Is it in fact used as observable behavior for violent activity that could then hold the person for a longer period of time? Just from time to time in general does that happen?

MS. HUGHES: I can answer that. In San Francisco the Advocates do not represent patients in probable cause hearings and a lot of other counties they do and in my county we do. Resistance to seclusion, trying to get out of seclusion, is often used as evidence that the person is a danger to others. In fact, statements that are used as evidence in the hearing review record are statements like patient appeared angry in the hearing, patient has been combative and has resisted seclusion.

ASSEMBLYMAN BRONZAN: Okay, then the follow-up question I have on that is that that statement that you would quote appears in the proceeding and that statement comes from the professional, theoretically, who was handling this person? And who wrote the statement in the first place that the person appeared angry or was hostile or resisted.

MS. SCHWARTZ: If I could interject here. Usually it's the nurses--or the psych-tech on the floor who makes observations on a daily basis. I've seen the same thing.

ASSEMBLYMAN BRONZAN: So it's the professional in a facility .....

MS. SCHWARTZ: Yes, and sometimes it's not really the doctor. In some cases it could be the doctor but often it's the day-to-day caretaker.

ASSEMBLYMAN BRONZAN: Okay. And then at that point - this goes back to a question I asked earlier and I'll ask it again with one of our other witnesses - there is generally

no other testimony to the contrary is there?

MS. SCHWARTZ: Right, when there's no one else there.

ASSEMBLYMAN BRONZAN: Either for that particular incident or just in general about the person, there's no other opposing testimony about the individuals.

MS. SCHWARTZ: Yes. You don't really have time to--usually the family is also agreeing with the lock-up decision and so there's really nowhere else to go.

ASSEMBLYMAN BRONZAN: Okay, one last question on this and then I have one other question before you proceed. Obviously a situation like that could be extremely unfair to a person where a person is--where you and I would react in exactly the same way, yet that would be used against us to hold us for a longer period of time and that is an outrage and we shouldn't tolerate it. On the other hand, certainly there are people who would be just--they are in fact violent and that is reflecting what we're trying to get at with the law in the first place. The question is how do you distinguish between the two?

MS. MATULIS: Okay, one of the problems, too, is that it is so vague, especially on the 5150 level. The fact is that a person can be brought in for looking like, you know, violent, and under suspicion for evaluation, but that's what I think I'm trying to get at is that it's so vague that when a person gets--once they get into the system all kinds of things can alter how they would normally act. It's not really a good sample of that person's activities.

ASSEMBLYMAN BRONZAN: I understand, but do you have just a simple explanation? Maybe it's impossible, but how does one distinguish between the two, because you're going to have some bona fide cases and some are really not where it's an abuse of the system. How do you distinguish between the two in a practical way?

MS. MATULIS: Okay, again, like I say, within a locked setting that's an intrinsically threatening situation for many people that they might be reacting towards what they perceive as a threatening situation - it's hard to make that distinction - but you could also say that if something is obviously unprovoked, you know, if somebody is--there's a difference between somebody who is taking an aggressive act and someone who is taking a defensive act. I mean, that's one distinction but I certainly don't think that that could account for the whole problem.

ASSEMBLYMAN BRONZAN: Well, you're having trouble answering the question I'm asking and I appreciate that, it's a difficult question, but obviously .....

MS. MATULIS: Could you rephrase it because I'm just having a hard time understanding it then. Could you .....

ASSEMBLYMAN BRONZAN: Well, I mean, you're obviously going to have people whose sickness makes them very violent and that is what the Act was trying to get at in that specific case and trying to hold those people. You know, when there's an abuse of that we're horrified and that's why you're doing the good work that you're doing, but what I'm

saying is how do you distinguish between that and the case where we need to have a hold of that person? I mean, maybe I'm rhetorically saying it's difficult to determine at times.

MS. MATULIS: Yeah. I think so and I also think that it's important to maintain these external standards that are outside of clinical judgment, because if we rely too much on clinical judgement, as we know there's not really a good statistical base to predict dangerousness, and I think that that's why it's--you know, like the LPS thing is so important to maintain, but it needs to be more specific, somehow it needs to be more observable. Sometimes people are violent and it has nothing to do with the mental disorder, but then they go--I know of a disabled woman right now who has been taking frequent beatings from someone and she can't even get the police to actually press charges against this person, but at the same time this person is committing a crime. Yet at the same time for much less observable manifestations a person can be held up indefinitely or for a much longer period of time.

ASSEMBLYMAN BRONZAN: Okay. Let me ask one question in a different direction. Back earlier, a few paragraphs in your statement, you were talking about the physician, if I recall, who had somebody shifted from a voluntary to involuntary status, or there was an attempt at that and the purpose of which was so that drugs could be administered?

MS. MATULIS: No, it was actually an involuntary patient who wanted to be there but was not allowed to choose voluntary treatment. Even though the law says that you can be able and willing to accept treatment, they were not able--there was basically a sub-version of the law.

ASSEMBLYMAN BRONZAN: They wouldn't let them go to voluntary because of the .....

MS. MATULIS: Because they could have been U.R.'d out of there if they had refused medications.

ASSEMBLYMAN BRONZAN: Okay, I'm glad you clarified that - I misunderstood that. But let me ask a question that's related to that. Are you aware of situations where when a person does become--when they lose their involuntary status and become voluntary - okay? - they become a voluntary patient, and they were involuntary at one point - that the point that they become voluntary that the doctor will refuse to see them because they're no longer covered by Medi-Cal, are you familiar with any cases like that?

MS. MATULIS: I'm familiar with cases like--some cases like that, yes, especially like in the context I was just describing which was a locked facility where the doctor was acting like, okay, if he didn't want to accept this particular treatment then I wouldn't see him at all, and the rationale was that he would be not refundable.

ASSEMBLYMAN BRONZAN: Are you aware of any cases where the Medi-Cal field office would define medical necessity as involuntary, therefore if it was voluntary they would not give a criteria of medical necessity for which a Medi-Cal reimbursement would follow? Do you understand what I'm saying?

MS. MATULIS: I do. In other words, you're saying that the requirement be that they're involuntary patients if they want to be there. Like another is if they want to be there we won't treat them; if they don't want to be there we will. That kind of--sort of .....

ASSEMBLYMAN BRONZAN: I think I need to ask this of somebody at the state because we could have a major problem within Medi-Cal, is what I'm pointing out - I've heard this - and I'm just wondering if you can substantiate it, that we end up losing Medi-Cal payments if the person becomes voluntary. And if that's the case then that's, you know, there's something terribly wrong with the Medi-Cal side of it.

MS. MATULIS: Oh, it is, but yeah, exactly, and it's like---in other words, you define the need for treatment by the fact that the patient wouldn't want it if they had a choice. I mean, it shows that that person is only there because they want to be there, not because they need to be there. There's some sort of implication like that which doesn't make a whole lot of sense, you know, especially since a lot of the service they need aren't really medical services. But, it's--you know, thank you for asking this question. I wish I could be a little more helpful.

ASSEMBLYMAN BRONZAN: It's okay. I'll ask the state Medi-Cal people.

MS. MATULIS: But as I say, the standard for danger to others is very vague - it does need to be specific and it needs to be upheld. What we do have needs to be upheld but it needs to be more specific than at the discretion of one person who goes out and just feels threatened and then when I asked why, couldn't even really say but just said the person was screaming, "I want to talk." You know, it would be very sensible to say well, let's sit down and talk, but they felt that she was incapable of talking. See, if the standard was more specific, then this kind of personal discretion that affects so many people's lives wouldn't be allowed to exist and it really has a damaging effect on people.

One of the other problems that is really related to this is the fact that there really are no rights that are comparable to Miranda rights - the right to keep your personal feelings and thoughts to yourself. People are not told that what they say can and will be used against them. In fact, they are pressured and badgered into revealing personal information that can then be used against them and they're not given any right to remain silent and that silence is often interpreted as mutism or refusal to cooperate. And a lot of times people just don't want to say anything because they're afraid that they'll reveal something that can be used against them, and so they opt to stay quiet and then that's used against them, and there has to be some sort of rights of protection. There was a woman that was picked up right here in Sacramento by a sheriff, a Sacramento sheriff, and he actually told her, he says, "Well, you are really one of the only groups of people I know of where the Bill of Rights does not apply." He looked back and said that to her in the back seat. He actually said that she didn't have the rights of other

citizens. So that is something that we really need to look at, too, even though it's not really part of this. But it relates because it has to do with involuntary treatment and if what you say in confidence, especially under pressure, when they're pressuring you to say things, and your deepest feelings and maybe anger, because they're trying to get at that and then that's turned around and used against you later at a hearing, that can be really destructive. And again, it's not very therapeutic.

I just want to wrap up with a brief comment on incompetence. I have the same sort of difficulties with the idea of incompetence to decide whether or not you need an evaluation. With the evaluations themselves, I sometimes really question if the evaluation itself were like proved to be a real good tool that was real equitable and real fair and scientific and even competent, I would have a few less problems with this. But I had a situation where a woman came in and was on one ward of the hospital and she was given phenothiazines. Then she was transferred to another ward of the same hospital and was changed to lithium carbonate. Then she started to have little tremors so they took her up to the geriatric ward because they thought she was having small strokes or TI's. They brought her to the geriatric hospital and then the psychiatrist - excuse me, the geriatric ward of the same hospital, the geriatric/psychiatric ward - the doctor there said, oh, she's not having a stroke, she's having a reaction from the lithium and then sent her back to the same ward. So within like two weeks this woman was seen by three different doctors, had three different diagnoses and had different courses of treatment. Now, talk about competence. I mean, this woman was not being--she was not there on her own free will. Now, who's less competent? The woman who's getting this treatment or the people who are doing all these strange things to her? And then by the time she was finished she was so confused and so muddled by the reactions of the drugs that she was in worse shape than she was when she came in. And so I really do have difficulty talking about competence to accept an evaluation that's questionable competent to begin with.

I just want to wrap up by saying that I think that the LPS is a really good start. I think it really needs to be much more clear. I think that the rights of people need to be protected and that the treatment of people who are in this system needs to be protected. The fact that a person can be an involuntary patient and not even be explained right now, they don't even need to be explained what the drugs are doing and why they're doing, and a lot of times they don't understand the effects. There is no informed consent for involuntary patients. And there's a woman in Napa right now who is there because somebody determined that she wasn't competent to stand trial for a small theft. Her lawyer believes that she would be out right now, except that because a doctor made a determination she wasn't competent to cooperate with her attorney, she's in Napa and she's there for much longer than she would have to be if she were facing charges.

So I think that we really do need to look at this and thank you very much for your attention.



SENATOR MCCORQUODALE: Thank you. We appreciate your comments. Are there any questions? Okay, very good. We thank you. I would just say for everyone's knowledge, if you could provide us with a written statement it would be helpful, and anyone else who would like to either provide on the same issues or their own comments, if they could get them in by October 15th we would include them in the record. Very good, thank you.

MS. MATULIS: Thank you.

SENATOR MCCORQUODALE: All right, our next panel will be talking about clinical and legal issues. We have Byron Chell, who's the author of "After a Decade of LPS - Uncertain Times in Mental Health Law." We have Dave Meyer, Head Deputy Public Defender of Los Angeles County. There's the person for your question. Captane Thomson, M.D., California Psychiatric Association, and Beverly Abbott, President of the Conference of Local Mental Health Directors. Do you want to go in the order that I called you?

MR. BYRON CHELL: Yes. Good morning. I'm Byron Chell. I do have some background in mental health legal issues. I'm the former chief counsel of the Department of Mental Health. I served for three-and-a-half years in that capacity. I'm now in private practice in the Sacramento area and have no continuing formal involvement in the mental health community. So I'm representing no one today except my own views, I will say that. I always thought I was impartial before but I'm sure I'm impartial now.

I have lots to say about this stuff, a tremendous amount to say about it. I've spent much, much time thinking about it. I still do. I do have a continuing involvement and then I teach law medicine and ethics at the University of California Davis Law School, and we do deal with involuntary commitment issues, because it is a good example of areas that confront society involving law, medicine, ethics, even morality and theology if you want to start talking about the areas of individual responsibility and what all that means in taking away that individual freedom.

I won't say everything I have to say about this. I did do an analysis of LPS - copies of it are available - it's 114 pages long. I will say that it seems to me that all that was said in that analysis at that time three years ago is just as relevant today and I stand by those conclusions. The only thing that perhaps doesn't need to be dealt with is the area relating to Gallinot and the implementation of certification review hearings. Now, also there are many people in this room who are probably tired of hearing me talk about all of these issues and how they relate.

I think it's important for everyone to realize the difficulty of these issues. We struggle with these issues because they are simply very difficult and if we don't completely understand them, you know, I would like to tell people that's okay, we don't understand them because they're very difficult. This is one of those areas confronting society where we have rights and conflict. All the difficult social issues confronting us today in our society involve rights and conflict, whether it be abortion, prayer in school, involuntary civil commitment, some of these other bio-medical/ethical issues.

In other words, regardless of what side you take on the issue, you can point to some fundamental concepts and fundamental rights and moral issues and all of this to buttress your argument. So they're tough issues and we have to recognize that.

Also, I have so much to say that perhaps I'd be better at answering questions or responding to concerns. I've heard much already that I could respond to but I won't. What I'm going to do is just make some general comments, very general comments concerning some of the problems that seem to me still face us that faced us three years ago. Basically, I think the LPS Act is still quite sound. What I mean, I don't think we need another revolution in the mental health law that came along in 1969 with the LPS Act. It's a pretty good act. This is evidenced by the fact that as was stated earlier, virtually every state in this country has adopted mental health laws based on the LPS Act. However, we've had 15 years experience now working with this Act so we've learned some things. And it was because of that, when I did the analysis, we called it, "After a Decade of LPS," so we've had a few more years experience. So we ought to think about our experience and where our real problems are and what we're really trying to do to see if we need to make any changes.

Let me just touch shortly on four different areas: Civil commitment criteria, the procedures, the right to refuse treatment and children - just very brief comments. In regard to civil commitment criteria, as you've heard, we can involuntarily civilly commit somebody in California if they're a danger to others, danger to self or gravely disabled. It seems to me that - well, again, I've discussed all of this in detail in this analysis so I'm not going to go into it all - theoretically it would be nice, I think, if we did something with the danger to self, gravely disabled concept. I think conceptually they're very similar to one another and we have some confusion around the state in applying them. In other words, who's to be considered gravely disabled, who is to be considered danger to self, and what's the difference here? I don't think it's necessary but it might be nice if we thought about that a little bit. This is a very difficult area, also, because of the different perspectives involved. I mean, the perspective of family members is going to be very different from the patients who are brought into the involuntary commitment system, as the perspective of the legal profession is very different from the perspective of the clinical profession. And it's very important to understand that all of those perspectives are legitimate and we have to attempt to put ourselves in those shoes and understand there are other perspectives so that we can achieve the balance that's required. Again, it's because we're talking about an area, we're talking about rights and conflict. Society has got to come up with a balance, what's the proper balance, and I think that's what LPS is looking for, that's what we're still looking for. And as Barbara Lurie said, the fact that there is continuing debate from all the different sides can either be an example that either something's wrong or something's right. I think it's a good example that something's

right here.

I don't see the need for any radical changes to our civil commitment criteria relating to either danger to others, danger to self or gravely disabled. It is somewhat vague but I don't think you can do anything about that. There is going to be differences in interpretation but I don't think the Legislature can solve that. I think you can solve that by education, training, that type of stuff. There's very little education and training in regard to what involuntary civil commitment is all about. You know, what's the concept behind this, what are we trying to do and why, or what is the legal basis, the constitutional basis, what are we trying to find, what must we find? So in summary, I don't think we have to do a lot there. That is my opinion.

In regard to procedures, you heard that we have a system, you know we have a system where we have 72-hours, 14-days, and then depending on what your classification is you can go different ways. I would like to say, and it was discussed back in '80 and '81, serious consideration be given to the idea of extending the initial 14-day certification to maybe 21 or 28 days. Did lots of talking about this - there's some compelling arguments for doing that - there are some arguments for not doing it - but it's something that I still think would be deserving of serious consideration, especially now that we have automatic certification review hearings upfront which, theoretically, should add more protection to the rights of the patient being involuntarily detained.

The right to refuse treatment - this issue has confounded the mental health community for five, six, seven, eight years. I'm still amazed personally at how much confusion is still caused by this concept and the litigation that's gone on around concerning it. First, the right to refuse treatment, in my opinion, is not about the right to refuse treatment at all. What I mean by that, and as I've continually said, it is not going to be--we're not going to get to a situation where we have involuntary commitments of people that you cannot involuntarily treat. That's not what involuntary civil commitment is about. It's about involuntary civil commitment for treatment purposes. Again, we could talk about this for a long time, but the right-to-refuse-treatment cases are all about is what procedures must you follow before you can involuntarily detain somebody. All right? I think it's very important to understand.

This brings us right to the issue if incapacity and incompetency. Now, there is absolutely no way to justify involuntary detention and forceable treatment without making a finding that the person isn't capable of making these care and treatment decisions for themselves. You cannot justify it legally, ethically or morally. If you don't take that position then you have to take the position that it's okay to involuntarily detain a person and forceably treat them with anti-psychotic medications perhaps, even though we think that they're capable or competent to make these decisions for themselves. That's absurd! We have to make this finding - that concept - you know, arriving at that conclusion is fairly easy. The difficult part is trying to implement it either legislatively

or administratively. Again, I spent much time in the analysis talking about this problem and the need to make this type of a finding - if you do make it, what's it mean? It certainly shouldn't mean a finding of incompetency for all purposes - it should be a very limited finding. We have to talk about substitute decision-makers and we have to keep in mind, you know, if we're going to implement it we have to implement it in a system that is workable. We can't be holding full judicial hearings for everybody certified for 14 days, for example. It's a very difficult issue. I still have that to say about that issue - we must make that finding because we are not in the business of forceably treating patients who are capable of making these decisions for themselves. It's that simple. Now implementing is a little bit more difficult.

In regard to children, we have some comments relating to children. The Roger S. decision is a very difficult decision. With certification review hearings in place, I can see that it would be much easier to implement that system in regard to children right now. However, I'm not sure it ought to be done because there are still some very troubling issues surrounding that decision, and my personal opinion is I would like to see the Roger S. question relitigated. I don't think it was adequately dealt with. I don't think that's going to happen but I really don't have anything to offer, anything new to offer in regard to the problem of children right now.

Well, again, I have lots to say about all of this. My experience is that the problems that we encounter in this system - we hear instances of individual abuse perhaps or something went wrong, horror stories - but this is generally not the result of anything wrong with the LPS Act. It's generally a result of, you know, not understanding what the Act is all about, not understanding what society is all about in having an involuntary commitment system - a lack of education - something went wrong. You know, what I mean by this is I don't think I've ever heard a horror story or an abuse story where I couldn't identify what went wrong here and it's not the statute. I mean, this person simply-- you know, the police officer did something wrong or the hearing officer or the judge really didn't understand what ought to be done here, so it's that type of thing. So I'm not going to sit here today as I did back in 1980 or '81 to say that we need massive changes to LPS.

My experience in the mental health system is that the problems, the real problems relating to the mentally ill, you know, are not these legal problems. These are interesting problems, they're fascinating for lawyers and they're fascinating if you're interested in ethical and moral and legal principles and all of that. But these aren't where the real problems are. I always saw the problems to be around - and we've heard some of them today already - the problem surrounding the lack of continuity of care, for example. Problems surrounding the stigma of mental illness. I still see that as a tremendous problem. The public perception of this seems to me is look, we want you to take care of these people and we don't want these weird people on the street, so we want

you to take care of them - we don't want to hear any horror stories or abuse, you know, all that horrible stuff going on in the state hospitals, so we want you to take care of them, take care of them well; but listen, don't spend too much money and don't do it in my neighborhood. And if there's one thing I think that you as legislators can help do is whatever you can do to dispel this notion that most mentally ill people present a danger to others. You heard the statistics today - they're surprising statistics - 196 people statewide on the basis of danger to others. By far, by far the people who are held in the involuntary commitment system are people who for one reason or another can't care for themselves. They're no danger to you, to me or to our children. They simply for one reason or another can't care for themselves. The public perception is just the opposite. If they're mentally ill, they present some kind of danger, you know, do something about them.

So then the lack of resources, the lack of social services, how many people are in involuntary civil commitment in acute care settings, when what they really need is some help with the problems of living - either they don't know how to find a place to live, they don't know how to shop. What they need is social services perhaps, not acute care. That doesn't mean we don't have people who don't need to be involuntary committed and involuntary treated in an acute setting, but I often wonder how many could be helped out of that system with additional social services.

Well, like I said, I could go on forever. Those are my written comments. I still stand by them and I'll just shut up at this point.

SENATOR MCCORQUODALE: All right, very good, thank you. Dave?

MR. DAVE MEYER: Thank you. I'm David Meyer. My job description on the agenda is accurate but I would like to make clear that Los Angeles County, of which the public defender is a function, has not taken positions in any of these matters. So these are my own views, although I look forward to being involved on behalf of several groups during these discussions as they go on.

I have some eight plus years as an attorney for mentally disabled individuals in LPS proceedings, developmental disability proceedings, penal code proceedings relating to the mentally ill and similar proceedings, and I'm willing to answer questions or make comments about any of those areas that I can help shed light on because of my experience.

I have a particularly strong feeling, however, about one area, and that is the area of mental health treatment as it relates to children. I strongly feel, I have felt for years, I will continue as long as I am in this field to continue to believe that government has a particular responsibility to protect children in this area. It is a responsibility that arises from the obvious. First, children are legally disabled as individuals. Someone under the age of 18 years is legally disabled by definition. Secondly, an individual who is under the age of 18 years and who has severe mental disability has additional problems for which government I think ought to have a responsi-

bility. I do not think it is enough and I think the law supports me in this area, to say that these kinds of problems can be solved in private settings and by the family alone.

There is especially amongst needy families and for needy children a need to provide systems and treatment. They do not exist now. That is not a deficit of the LPS Act, it is not a deficit of the Lanterman-D.D. Act, it is a deficit of available funding and available facilities; and, of course, you've heard that sawover and over again today and you'll hear it over and over again, I'm sure, as time goes on. There does need to be revision of some of the gatekeeping functions in the LPS system and we can get into that in more detail. But there needs to be the ability of children who are disabled children who have severe problems to get into the system. It is difficult now. Again, not especially because there is a deficit in the law but because there are deficits in the organizations, institutions, bureaucracies that deal in these areas.

Secondly, there is a need to protect children in another way, and I would emphasize in this area especially the vulnerability of children because of their legal disability, and that is to protect children against abuses in the private sector. There are, although these are hidden, rather--there are large numbers, a rather vast system, if you will, of privately funded juvenile halls that are licensed to function because they have licenses as mental health treatment facilities. Children are in them, receiving rather severe forms of behavior modification therapy, if you will, behavioral technology at its utmost. These children are artificially labeled as mentally disordered, mentally ill. They are permanently, publicly and forever branded as mentally ill people. There is no regulation that is meaningful of these institutions. There is no body which on a regular basis checks to see if they're operating properly. There is no voice of the Legislature, of the people of the State of California of the manner in which they are operated or the manner in which the children who are held in them are treated.

In order to address both of these problems there is a need to address certain unanswered questions, certain issues. These issues must be addressed and I beg to differ with my colleague, Byron Chell. These issues must be addressed by the Legislature and not by the courts. 1977, the case of Roger S. was handed down by the California Supreme Court. There was no mechanism suggested by the Supreme Court for implementing the decision except that the Supreme Court in a footnote suggested, well, the Legislature will take care of it. It is now 1984. I have personally been involved in at least three attempts to take care of it - it has not happened. The problem has not only continued to exist, it has grown to the point where it is entirely possible that it can't be addressed at all.

ASSEMBLYMAN BRONZAN: What is taking care of it? I mean, what's the resolution?

MR. MEYER: There is a need for legislation to address the problem of individuals who are not mentally disordered being in mental hospitals. There needs to be a mechanism to prevent individuals who are not mentally ill from being artificially labeled as such,

being held for very long periods of time in these kinds of institutions and forever suffering the stigma of having that done.

ASSEMBLYMAN BRONZAN: Are you talking about children?

MR. MEYER: Children. Now, these are not LPS commitments. They're private commitments. Someone walks up to the door of a mental hospital, signs themselves in. There is a similar problem with a case handed down by the California Supreme Court known as in re Irene Hop. That decision required that there be -- in a manner very similar to Roger S., by the way -- that there be a determination prior to hospitalization of the need therefore. We still do not have meaningful legislation in that area.

ASSEMBLYMAN BRONZAN: May I ask a question? I want to make sure that I understand this clearly and I'm afraid I don't. You're talking about not LPS commitments; you're talking about private commitments.

MR. MEYER: That's correct.

ASSEMBLYMAN BRONZAN: Of a minor to a private institution.

MR. MEYER: In respect to the Roger S. phenomenon, if you will, (quote, unquote). Yes, in re Irene Hop relates to hospitalizations in state hospitals for developmentally disabled people. But in re Roger S., yes. My down-the-street mental hospital with 40 beds in it that's licensed by the state operates under Section 1250 of the Health and Safety Code -- I don't like the way my child is behaving -- perhaps they're staying out too late, they're a runaway, they use too much alcohol, they're sexually promiscuous, a variety of other things -- I march my child on down to my corner hospital, knock on the front door, get them admitted and they might stay there for eight, ten, fourteen months.

ASSEMBLYMAN BRONZAN: Okay, I need to understand legally before you go on. Who determines involuntary at that point? Is it the parents' refusal, or the child's refusal?

MR. MEYER: Unfortunately, the terms voluntary and involuntary are ill-suited to describe this.

ASSEMBLYMAN BRONZAN: They don't make much sense here.

MR. MEYER: They make no sense whatsoever.

ASSEMBLYMAN BRONZAN: So a parent can just go and take their child for whatever reason and have that child committed to a hospital that's functioning like a locked mental facility -- is that right so far?

MR. MEYER: It is a locked .....

ASSEMBLYMAN BRONZAN: It is a locked mental health facility, and then you said, also, that that child can be labeled by that private doctor and that private facility "mentally disabled?"

MR. MEYER: They must be labeled mentally disabled, otherwise the admission is improper, inappropriate.

ASSEMBLYMAN BRONZAN: By what standard is it improper?



MR. MEYER: Section 6000 of the Welfare and Institutions Code requires that that person be a suitable person for admission to a mental health hospital. Obviously, someone who is not physically ill should not be in a general hospital. One who is not mentally ill should not be in a mental health hospital.

ASSEMBLYMAN BRONZAN: Suitability means they must be declared mentally disabled or something like that, and then they are tagged and then the hospital and there's no control over the person.

MR. MEYER: They must be diagnosed as having a mental disorder, which is, as you've I think gathered from other testimony, a rather simple process. The process of diagnosing mental disability is a process of simply describing the obvious by fancy words.

ASSEMBLYMAN BRONZAN: So all of the hoops that we jump through in LPS don't apply at all to what you're describing.

MR. MEYER: That's correct. There are no hoops. Do not pass go, do not collect \$200, the door slams shut behind you for an indefinite period.

ASSEMBLYMAN BRONZAN: Based solely really on the parents' desire.

MR. MEYER: Well, I would quarrel with that, although that's the legal theory. Usually parents are attracted to these situations either by the recommendation of a mental health professional or by advertising on television, magazines, newspapers, etc. - bring your misbehaving child to our mental health hospital and we will cure him of the misbehavior.

ASSEMBLYMAN BRONZAN: Okay.

MR. MEYER: There is a need, as one who believes strongly in the rights of mentally disabled people and one who has fought for them in the courts and elsewhere for many years, I can see the need for there to be mechanisms to address the so-called Michael E. problem - the inability of juvenile courts to take individuals who are either dependent children or who are wards and find for them within the system appropriate mental health treatment. There is, unfortunately, a substantial number of young people in Los Angeles County, many of them held in our own McClaren Hall, who are there not because their parents are incapable of providing for them but because their disabilities are so great, their mental health problems are so severe, that they must be locked up somewhere and there is no other place to get them the help. There is a need in the juvenile system to have mechanisms to address this problem.

I might say to you that the LPS Act does have provision for addressing the problems of mentally ill children. There is a special definition for "mentally ill minor" which is rather more broad in many ways than the definition for adults. There might well be the need to address that definition so that we can more easily and more accurately identify those children who should be in the system. But I would say also that there is an equivalent need to identify those children who should not be in the system. The LPS Act, as it operates in respect to minors, operates as it does now, and I am including

in re Michael E. in these comments. It operates as it does now because of the massive, pervasive abuses of placements in psychiatric hospitals prior to LPS and prior to in re Michael E. State mental hospitals are not a place to address the needs of misbehaving children. State mental hospitals cannot do that and they do not want to do that, yet very often they're the only places that--they're the place of last resort and the only places available for some children who have severe behavioral problems, severe developmental problems.

Any law that addresses Roger S., Michael E. and related issues must not only address the need that has been created, but address the need to prevent a return to the kinds of abuses that we had prior to the LPS Act. I have no other formal comments.

SENATOR MCCORQUODALE: All right, we're going to take a brief recess.

- RECESS -

SENATOR MCCORQUODALE: All right, we're ready to start again. Now we will go down to Dr. Thomson.

DR. CAPTANE THOMSON: Mr. Chairman, I'm Dr. Captane Thomson. I'm Director of Mental Health in Yolo County and I'm here representing the California Psychiatric Association. And I will be drawing from the model state statute for mental commitment of the American Psychiatric Association that was approved in 1982 for some suggestions about changes in criteria and procedures.

The most frustrating thing to those of us who have to testify, and for families, is that our testimony does not relate to the central issue in commitment hearings, and that is the need for a severely mentally ill person to be treated to prevent deterioration. I would agree with Byron Chell about the issue of grave disability and danger to self could be collapsed, and I would suggest that in combining them that we also consider adding the additional criterion that the person be likely to cause harm to himself or to suffer substantial mental or emotional deterioration.

Now, the way that would work, our present 14-day certification on medical grounds would be replaced by a 30-day commitment. The 30-day commitment would be made by the court, not based on the psychiatrist's certification alone. The court would have to make the following findings:

1. That the person suffers from a severe mental disorder;
2. That the disorder is treatable and that the treatment will take place in the least restrictive alternative setting;
3. If the person refuses or is unable to consent to treatment voluntarily;
4. The person lacks the capacity to make an informed decision; and
5. The person is likely to cause harm to himself or suffers substantial mental or emotional deterioration, or likely to cause harm to others.

My final recommendation would be that commitments should be made to treatment whether that treatment be on an in-patient, day-patient or out-patient basis. In other

words, we should provide commitment to out-patient treatment as well as to confine that we should unlink commitment from confinement.

SENATOR MCCORQUODALE: How would you, Doctor, respond to testimony from the Patient Rights Advocate, Colette Hughes, who felt fairly strongly that involuntary detention and forced treatment do not help hold down the suicide rate and that it might, in fact, contribute to it? Is that your feeling also?

DR. THOMSON: Well, of course, those of us who are treating patients see many people who are acutely suicidal during a crisis who are brought in for treatment and who as a result of treatment are thankful that they've been rescued. Many people have taken overdoses of sleeping pills, for example. When they recover they're grateful that they've been treated and rescued. So I believe that one of our duties to our neighbors is to try to help them when they're not able to help themselves.

SENATOR MCCORQUODALE: The comment was made that the 30-day period of time is adequate to determine if a person is really suicidal or if it's just an attention gainer. Would that be your opinion also?

DR. THOMSON: By and large, people who are acutely suicidal can be treated within the--well, now we have the 3 days plus 14 plus another 14, a total of 31 days. It's rare that we have to let somebody go knowing that he's determined to kill himself. That can happen, but I've never had a case.

SENATOR MCCORQUODALE: What about the issue that we shouldn't force treatment on a person without the specific finding that the person is incapable of making a treatment decision?

DR. THOMSON: I think that both the Gallinot - the probable cause hearing we have now - and the Jamison argument that a person's capacity to give informed consent should be determined, but they should be determined, in my opinion, by the judge at the time of commitment and that commitment should occur immediately after the emergency detention. So a person would be held as an emergency - if there's a decision to keep them longer, say for a 30-day commitment, then that should be a court determination. I think now we're having all kinds of (inaudible) court decisions. We have probable cause hearing officers, we have independent psychiatrists doing these evaluations - I think it would be much less expensive and much more--and would guarantee people their legal rights much more clearly if this were done upfront at the time of the initial commitment.

SENATOR MCCORQUODALE: All right, thank you. Any other questions?

ASSEMBLYMAN BRONZAN: Not right now.

SENATOR MCCORQUODALE: All right. Beverly Abbott.

MS. BEVERLY ABBOTT: Yes, thank you, Mr. Chairman. I'm Beverly Abbott. I'm President of the Conference of Mental Health Directors currently and the Mental Health Director for Marin County, California. I would like to make some general comments and then a few specific ones.

Obviously the questions that you're asking today, as you've said in the written material you sent out, are too complex to answer in one day, and it's good that you'll have the task force format. We hope that we will have an opportunity as people who work in this system to participate on those task forces and to discuss the issues in more depth. But I would like to say a few things about the context in which those issues might be looked at.

I agree with many of the things that have been said here this morning. The first that a voluntary connection with the patient is always optimal. And while I think we always assume that, I think it's sometimes easy to lose sight of how often that is possible. Marin County has the highest per capita of funding on the property population model. So we have a relatively small well-funded system and it's easier to see that the more resources you have the more you're able to reach out to a client to offer voluntary alternatives. Many clients who in a more pressured system who might not respond do respond under that system. Even in the most optimal of situations, however, you will have clients who society has to make that decision for them, because without care and treatment they would go out in the street and not care for themselves at all, perhaps be hit in traffic or any number of horrible things.

The second point I'd like to make in general context is that however you look at LPS, and we look at LPS, it's important to do that, understanding how the limits of our knowledge about mental illness - and in your first hearing I think you had some expert testimony on the nature of mental illness, the complexity of it, the many factors - working as people in administering this system. The way that that translates on a day-to-day basis is that you're often not sure what will happen with patients. So in preparing for coming up here today I talked with several of my best clinical staff - these are highly trained people with a lot of experience - and also being in a small system people who know patients individually - and the question is how good are we at predicting what will happen with someone over the next few months. And on suicidality and dangerousness, my staff had to say, you know, we're really no better than chance often at predicting. And on grave disability, if we know the patients well, maybe we are as good as 70 percent in saying this person will deteriorate without, but that still means that we're wrong 30 times in 100. So within that context we are administering a system where we have to be humble about when we're restraining a person's liberty, or taking away a person's liberties.

The third general context statement, as an administrator of this system, it is very hard and the reality of being both the treater and the person who takes, or the people who take away the patients' liberties is a constant moral, ethical, professional dilemma everyday, so that you really--society has charged us with saying you are both responsible for making sure the person's liberties are protected in the system and you're responsible for treating the person involuntarily. And it's a very difficult juncture

and at least perhaps some thought should be given to separating those two things. Now having said that I must also say I don't have any particular helpful suggestions to give you. But I think it's worth a certain amount of discussion in recognizing the tension that creates.

I agree totally with what's been said by a couple of the previous testifiers that if the person is committed to the system without the ability to treat that person, the only function we're performing is a social control function and that is not--that's an unnatural act for the mental health system for treaters in the mental health system, so that whatever the determination, if you hold someone against their will, it does make sense to say that then you are able to do whatever - you know, to the extent of the limits of your knowledge do what you know or what you have evidences of the best thing to do. But if you commit someone to us and then say at the same time you can't do the things that you know - for example, medication with an acute psychotic episode - that would be a terribly difficult situation and result in a ward where people both voluntarily treated and involuntarily treated who maybe would not take medication you'd have a patient--you'd have a very difficult treatment situation.

Having said those things as context, I think that on the whole specifically the criteria for treating the mentally ill in involuntary holds are fairly adequate with some exceptions. They are not adequate for children, as has been spoken to, and that obviously needs review and study and that mainly occurs because of the confusion about what's the parents' rights versus what's the child's rights, and that situation needs to be corrected.

The system would probably be improved if you could have a second 14-day hold on grave disability. In some counties there is, I guess, a filing of temporary conservatorships as a way to hold individuals beyond the first 14 days. And if you had a second 14-day hold period that may be sufficient for some clients. You may still go into the permanent conservatorship, but that might make an improvement in the system.

In terms of court testimony, part of the problem with conservatorships, and this may apply to the other two categories also, is judges interpret the law differently so that when you go to court, if you're dealing with a reasonable judge - reasonable as our opinion - that you can present evidence and you are able to get conservatorships. If you have a judge that takes a very strict interpretation - for example, a moment in time - they have a client before them and they say at this moment of time this individual is all right and can provide food, clothing and shelter - yet we have had that individual and treated them for five days - then that individual is released and they may go downhill. Another judge will take a lot of testimony about the history. In large counties it's a tremendous problem if the record can't be admitted as evidence because in a smaller system - like our clinical director knows all of the clients that come through the crisis units, so he goes, he testifies - it's sometimes easier in a large system where you can admit the chart. You would have to have so many people in court to establish a history.

So there's some interpretation problems there, but the system, I think if it works the way it was intended to, I think does work for conservatorship.

Danger to others is a category that doesn't work very well, we think. And the problem there is the mental health system. If the dangerous behavior flows from the mental illness itself, such as someone who has a delusion that they can be saved by cutting someone's throat - that's a specific example that comes up in different forms from time to time with patients - is that that individual, that dangerousness flows from the mental illness. There is a situation that I can think of where there's an individual who we consider to be dangerous. He has a DSM-3 diagnosis but it doesn't flow from a specific part of his mental illness. And those are very fine differentiations to get into and maybe we're not always right about them, but the problem that you have is if that individual's committed to the mental health system, what is the mental health system going to do anyway? In other words, unless you can specifically say how you see the dangerous--what the cause of the dangerousness is and what you can do to treat it, then you have someone coming into the system and you have a very--you are not--if it's not a treatable illness then you have an impossible situation. So the issue of danger to others should be looked at carefully from the point of view of what function is the mental health system supposed to serve, and I think many of us in it feel that that is not a function that we serve well.

You looked with surprise, I think, Assemblyman Bronzan, at the figures, the number of holds of danger to others, and even with the new criteria, the '83-84, I don't think you're going to see a large increase in that. It's difficult to get in court, it's difficult to prove, it's difficult to be specific about. Our strongest hold with people who are dangerous generally comes from the criminal justice system. So if you have people who have committed crimes against society, frequently individuals who are dangerous because of a mental disorder, that's your strongest hold. Mental health is often most effective when we're working cooperatively with the criminal justice system which has much stronger procedures than LPS does. And with children, again, as it's been said, that those criterion need revision.

I think it's important to look at, again, whether or not individuals accept treatment in what we have to offer, and also what causes them to come to us. Several people have spoken about housing, failure of SSI, other things - those I think are tremendously important to--Byron Chell talked about stigma and the community supports - those things are tremendously important about forcing people into involuntary treatment. That doesn't apply to everyone. There are some people you could provide housing and they would still require involuntary treatment. But, again, in a small system it's easy to see, if you can get in early with housing and money management, how often people have more choices.

Thank you.

SENATOR MCCORQUODALE: All right, very good. Thank you. Any questions?

ASSEMBLYMAN BRONZAN: I've got one question. Of all of you, briefly, because of where you all represent and your backgrounds, I'm just curious about one thing, just in your opinion, what is the - two things - what is the scope of the problem, or the percentage of the problem, whatever the easiest way to answer it, of those that need treatment but aren't getting it that are being kept somehow one way or another from getting it? And then, secondly, particularly with your background, what's the scope or the percentage of the problem of those that get involuntarily committed that shouldn't be that don't belong there? Is there just a simple opinion answer that each of you can give me on that?

DR. THOMSON: That's a wonderful question. You're asking a number of false positives and false negatives. That is, how many people are being falsely committed who are really not mentally ill, and how many severely mentally ill people who would fit the criteria are not getting treatment. There are very few people who are not seriously mentally ill who remain in the mental health system beyond the 72-hours. People can be picked up and brought to the hospital and then after three days released, and that may occur - they may be an alcoholic in a delirious state - they may be suffering from toxicity from drugs or there may be other reasons. But beyond the 72-hours, there are very few people who remain. And with our probable cause hearing mechanism now, people are screened down so the very many seriously mentally ill people are not kept because they don't meet the strict criteria of danger to self, others, or grave disability. And grave disability, remember, is limited to food, clothing or shelter, not safety or health or other more general considerations. Then there's nothing about the likelihood to deteriorate emotionally or mentally. Those considerations are not part of the probable cause hearing officer's responsibility.

Now, on the other side, we have, as you know, the depopulation, deinstitutionalization of our state hospitals. Everybody who walks downtown in any major city sees numerous untreated severely disturbed people. The problem of the homeless is a very major social and economic problem now in the United States, and many of the homeless are seriously mentally ill, people who are not getting treatment. You know about the lady who died in the cold in New York City because she was living in a box. The day that they arrived to finally, with a court order, to take her in they found her dead. So we are leaning over backwards to permit patients to stay in the community and we're allowing them to die with their rights on.

ASSEMBLYMAN BRONZAN: How about the other side capped real quickly - what percentage of the folks from just your point of view that get committed that really shouldn't be.

DR. THOMSON: I think that those who are committed--well, those who are held in the hospital beyond three days, I think the proportion would be almost negligible.

ASSEMBLYMAN BRONZAN: Okay.



MS. ABBOTT: I think that for those who are committed or who stay in the system that shouldn't be, I think in the better funded programs you might find some people on conservatorship longer than if you took strictly a patient's rights point of view than was necessary. But that is really the exception. I think LPS does function to keep us from holding people against their will and there are a number of different assurances of their rights. I think the people who aren't getting treatment, I am not convinced and haven't seen a lot of evidence that that's so much a fallout of LPS as it is from the resource, because the woman who dies living in a box would she have lived in a clean hotel given the opportunity and three meals a day? So I think that on the involuntary treatment that's a very hard one to assess without looking at the resources.

ASSEMBLYMAN BRONZAN: Dave?

MR. MEYER: I think you have to keep in mind that the operative mechanism of LPS is not treatment. You don't lock someone up for treatment, you lock them up because of their behavior. That is a decision that the Legislature made years ago and one which is absolutely set in stone now I think socially in terms of the system. Therefore, when you go into the hospital you will find people who almost uniformly need treatment because of the severity of their behavior and therefore you have very few misses. The LPS system functions very well on that level. Therefore, those who are in, if you will, there are very few misfirings. I think that is a credit to LPS. On the other hand, I can't say that I agree because I am looking, I think, at a sample which is much broader, that everyone who is in the hospital therefore should be there as I've mentioned. There's a whole sub rosa mental health system (quote, unquote) which has people within it who are not mentally ill in anyway that you or I think would accept it. They have what are known as adjustment reactions, which is merely another way to describe that they're mischievous, misbehaved, a variety of other things. They may be even anti-social. They may even be committing crimes. But mentally ill? I don't think that most folks other than those who need to use the DSM-3 would accept that.

ASSEMBLYMAN BRONZAN: Okay.

MR. CHELL: This concept of need for treatment as being a commitment criteria is a difficult one. A concept in conjunction with some of our existing criteria is all right to talk about, but to talk about civil commitment on the basis that a person is, for example, mentally ill and in need of treatment, that's incorrect. I think we ought to see this problem, see involuntary commitment of the mentally ill as the same as involuntarily treating somebody for a medical condition. As far as I'm concerned, the concepts are identical. That is, you cannot force a person to have their leg amputated unless you make a finding that their medical condition puts them in some type of a dangerous situation and they are not capable of making decisions in regard to that treatment. I mean, the fact that a person is in need of medical treatment is not sufficient to force medical treatment upon them. The same way the fact that a person is in need of and could

benefit from mental health or psychiatric treatment is not sufficient in and of itself, even though we think it's a terrific idea, it's not sufficient to override the individual's choice. We have to additionally find that they are in some type of dangerous situation and can't make these decisions for themselves. It takes a long time discussing this stuff to get it all straightened out.

Regarding the other side, my experience was never that you--you know, you don't see people - clinicians - you know, making these decisions lightly or generally making these decisions lightly to civilly commit people. This is important stuff and my experience is that they treat it that way. That doesn't mean that people aren't civilly committed who perhaps don't need to be civilly committed. After all, we must remember that we are simply human beings making very difficult decisions about other human beings. I hear just as many, and I've heard just as many complaints that, you know--well, you hear them from the family. It's not that so many people are getting in inappropriately as you don't keep them in or clinicians don't keep them in. And then, again, it's a balance.

ASSEMBLYMAN BRONZAN: I talked with many people in my own county but two people who have feelings about this - particularly one in which I received this morning - is a public defender who handles your counterpart in my county, and his opinion was that it's a slam dunk for the county at those proceedings because they don't have resources to bring anybody else in on the other side. So when the psychiatrist's testimony, or whoever testifies or whether it's written or whatever, on behalf of getting the person committed, there's really nothing else on the other side and it's a slam dunk as far as he's concerned. I asked him was that appropriate. I mean, that may not sound good but relative to the people who are going there, whether he's defending them or not, is that appropriate, and he felt that in most cases it was, that they in fact belonged there. But he felt that there's 10 to 15 percent that he's not sure about and for them that's unfair, and he's not sure that they belong there at all. But there's absolutely nothing he can do about it with his limitation on resources. I think it's an interesting comment.

The other comment was that in our in-patient psychiatric, many feel that it is so overcrowded that so many people are not kept there or not kept as long as they should be because of just the sheer volume versus the resources that are there to deal with them, that it's nowhere near as many as there ought to be relative to the need out there and that you have to be very, very, very sick to get in because of that backing up of that level of severity. I mean, obviously it will take a long time to sort all these things out.

One thing I think that's extremely important that's been raised several times by the panel before you and, again, by you, Beverly, is that one thing that skews all this and makes it difficult to compare apples and oranges and to sort it all out is just the lack of treatment capability period. And if you had a much larger range and continuity

of care, as you mentioned, in every community that could be accessible voluntarily, that would dramatically skew the whole concept of involuntary treatment. And I think as long as we're dealing with that basis with essentially a desert out there of good treatment capability for people, we will be forever plagued with these more impossible-to-resolve-totally issues for LPS and involuntary commitment.

SENATOR MCCORQUODALE: All right, very good. Thank you, we appreciate your coming. We need to take a short break now for the transcriptionist, the stenographer, to relax a moment, and then we will take up the panel on the system's monitors.

- BREAK -

SENATOR MCCORQUODALE: All right, we're ready to resume. We'll now go to Panel 3. Helen Teisher, President of the California Alliance of the Mentally Ill, and Jack Cunningham, Citizens Advisory Council, and Derek Washington. Dr. Washington's with the Mental Health Association of California. Helen, you want to start out?

MS. HELEN TEISHER: Thank you. We consider this a real opportunity and thank you for it.

I could spend a lot of time reacting to the people who have already spoken, but I will restrain myself. I must react to the statement that was made that it was most often the families who want to lock up their mentally ill relatives. That is not what we want to do. It is not truthful nor accurate to state that families will accrue support or condone insensitive or inhumane treatment in facilities. Until Saturday afternoon I could have told you truthfully that in all the thousands of families that I've come in contact with I have never met one who wanted to get rid of their relative. But Saturday I had a call from Texas from a society woman who told me that she was ashamed of her son - he was causing her a lot of difficulties in her social surroundings - and if I could find a place to put him in California she would pay up to \$1,000 a month. So she has spoiled my statement. That is one parent who is not concerned entirely for her son's benefit.

Going more specifically, I would like to answer your question about whether or not involuntary treatment does any good. A week ago Friday, my son, who is a schizophrenic, 22 years of illness, decided that he was God. The week before he had been Jesus Christ and the week before that he was John the Baptist. But on this day he promoted himself to God. He was at a board and care home and he began to order everyone around in the name of God. So his conservator called me and said we're going to send him to the hospital because he needs a little help. So he was taken by ambulance to the hospital. He came home, then, Saturday. In this week's treatment he had gained some semblance of health. He knew what reality was. He came home Saturday and stayed with his dad and me for about 10 hours and he was absolutely beautiful. His treatment had been involuntary. His treatment was the stabilization of his medication and he was placed where he felt safe. He suffers from hearing voices, the voices of the devil, and somehow when he gets behind those locked doors at CMH he feels safe and the devils go away. So I have to

say - and this is just the latest incident - it's been going on for years - and he has been under conservatorship for 15 years, thank God, and he is a perfect example of a person who sometimes needs involuntary treatment.

We do not believe that the mental health laws in California are entirely incorrect. We believe that this is not the time to panic and change everything. We do believe that some changes can be made in the present law which will benefit our mentally ill. I'd like to also preface my remarks by saying that I do not want any of my remarks to be considered derogatory or prejudicial to mentally ill people. After all, I am the mother, the sister, the aunt, the niece, the cousin and the grandchild of schizophrenic people. I think it's very appropriate that I am testifying before a committee on genetic diseases because in my family we know genetic diseases very well. This, I might say as an aside, is the main reason that I work so very, very hard for research, because I don't want a few years from now to add I am the grandmother of a schizophrenic.

In my work as an advocate for the mentally ill, especially in the last seven or eight years, I have known of numerous family crises resulting from mental illness in these families. I can testify without hesitation for the need for treatment for people who in crises lose insight into their own condition and fail to realize that medical treatment might help. We maintain that at certain times in the lives of some mentally ill persons, because of the deterioration of their thought processes and the worsening of their symptoms, that they are indeed gravely disabled.

It is with the definition of "grave disability" that we find problems. As the law now stands, "gravely disabled" means, as you've been told many, many times today, that this person is unable to provide food, clothing and shelter. This is much too simplistic. If the following provision were added there would be no need to change any of the procedural safeguards in the Lanterman-Petris-Short Act. We would expand the definition by adding this provision: "A condition in which a person, as a result of a mental disorder, manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her own safety or health." I think that would take care of a lot of the cases that you're hearing about where indeed someone needs to step in and take care of people until they are better able to take care of themselves.

I've had the experience, and I'm sure you could hear a lot of horror stories, and I've also been taught not to tell too many horror stories, but our own son came home one time after he had been lost for a while profoundly psychotic - dirty, disheveled, with lice and scabies, malnourished - and, of course, we took care of him and nursed him back, got him in pretty good shape, and then went to ask that his conservatorship be extended and that he be admitted to the hospital. The judge looked him over and said, well, you appear to be pretty well fed, you're dressed in clean, pretty good clothes and

you're certainly not malnourished. The judge did not say a word about the deteriorated mental condition. And our experience, my family's experience has been repeated many times with other families. One mother told me that she had been advised to take her son to the court as soon as he came home - don't clean him up, don't feed him up, don't take care of him, just take him to court and let the judge see what he looks like. Well, mothers being mothers you can't do that. You know, you take care of your son or daughter and then go to the court.

I find this subject the most painful of any that we deal with. I know that many parents, many families find it very, very painful, because we're not young parents, we've lived a life, we've been through civil rights, actions. I carried placards for the civil rights in the '60s. I've worked all my life for civil rights and freedom and it's very, very painful to me to ever say to anybody this person should lose his freedom for a while. I have nightmares, and believe me, people remind me about the Russians and I don't want this to happen to my son, I want him to have every right that he's capable of handling, and I want that for everybody else, but I'm also a realist and I think we have to be realistic. Mental illness does not come in a neat little package. It is not the same for everybody. Mental illness manifests itself in many different ways and people are hurt by mental illness in varying degrees. I know all that. I spent the last 22 years in San Diego County associating more with mentally ill than with (quote, unquote) normal and I know the different degrees.

I'm happy to know that there are safeguards against unwanted drug treatment. I know what drugs can do - I've seen it. I know what tardive dyskinesia is. I know that my son tells me that when he takes mellaril he's impotent. And when you do that to a man you take away that man's soul, his manhood, and you do it in the name of medication. So I'm very happy to know that there are going to be more controls, starting with Napa State Hospital, and I hope those controls are extended into the community where people do not have to have medication forced upon them. However, again, this is my dilemma. I sometimes think it's kinder to take people who are in such dreadful pain, and the medications do help, and to have them clear their minds and take away the terrible trauma of severe mental illness.

We are finding, and I'm absolutely certain that this is true, that a diagnosis of severe mental illness is very often not made upon the basis or the condition of that person, but on whether or not there are any beds or services available to that person. My son has been on conservatorship for 15 years and when he was first taken in for conservatorship hearing, it was no problem at all, nobody even questioned whether or not he was going to get the protection of conservatorship. And by the way, I am a very strong supporter of conservatorship. Some of the best servants I've ever known were conservators and they really and truly take care of their people.

I believe with all my heart that conservatorships are not being granted. I know

in my county because the funds are not available. And a person very high up in the bureaucracy in San Diego County said to me, "Why should we bring these people in wherein we have no place to put them?" You know, why is it? So that's something. I don't believe that funding and money is the answer for everything. I believe that the management of that money could be improved and I think we do need some more, but it's not the only answer.

Another thing that I think Beverly mentioned was that the judges sometimes base their opinion, their ruling on how well or how ill the person is on his appearance at the time of the hearing, and if a person's been in the hospital for a few days and medicated and taken care of and well fed, he's going to make a much better appearance before that judge than if this had not taken place. It's also true that many times we feel that the judges do not take into account the cyclical nature of schizophrenia and manic depression. And the ability of mentally ill people to pull themselves together is absolutely astounding. We see it happen all the time. And the judge is not allowed to look back in the records, at the record of recidivism at the things that have been going on in this person's life for a long, long time, and so his decision is made. And I heard someone here say that it used to be in the olden days that a conservatorship, or admission to the hospital was granted after a 4½ minute hearing? I visited the court, the mental health court in my county and those people are disposed of in one minute, not 4½. They just pass them through. That to me is inhumane.

I want to say before I close that someday I hope that the Patients' Right Advocates and the parents can work together because I consider parents the number one advocate for their mentally ill people. After all, these are our children. They're our flesh and blood. We don't want to harm these people. We don't want to get rid of them.

We are as much concerned with the rights and the freedom and the dignity of our relatives as anyone could possibly be and we certainly do not want to see a mass re-filling of the state hospitals or overuse of locked facilities. However, we do wish protection for our sons and daughters. We want care for them. And that's all we're asking really. We do not believe that just because a person might be experiencing thought disturbances, or delusions, experiencing delusions and hallucinations, that this is reason enough for involuntary hospitalization. If such a person is not causing or attempting to cause injury or death to himself or others, if he's not being neglectful and providing for his food, his clothing and shelter, he should be left alone to live as he chooses. If he chooses to forego psychiatric treatment, that's his right, as long as his safety and that of others is not jeopardized. I can give you a very good example of that that I know very well. I have a brother who's 78 years old and he's been schizophrenic since the age of 16. He has supported himself marginally in a variety of ways. He received no government aid, he's now living alone and enjoying his life. I saw him two weeks ago and he is still out of reality. He is still enjoying a much more grandiose and

exciting life in his world of fantasy.

ASSEMBLYMAN BRONZAN: Can he be reached by phone? (laughter)

MS. TEISHER: If he's not talking to the President. He's never been medicated, he's never been hospitalized through the entire 62 years of his schizophrenic life. I applaud him and I'm glad that society left him alone. He's totally harmless and he's lived a comparatively good life.

I will just summarize four things. I've already said one - the LPS Act should be reviewed and revised, especially in connection with the danger-to-self area. The ill person must be evaluated impartially by a medical staff with no consideration being given to whether or not beds and services are available. And judges, I don't know how the attorneys will tell me this is fantasy, but they should be allowed to review the history and not just make a judgment on the condition of the person.

I have one little thing to tell you. California Alliance for the Mentally Ill has just completed a survey, a questionnaire that we sent out to our own people, our own members. 75 percent of the people who returned this questionnaire stated that involuntary treatment had been helpful to their relatives. I think that pretty well summarizes our position.

Thank you very much.

CHAIRMAN MCCORQUODALE: Thank you, Ms. Teisher. All right, Jack Cunningham from the Citizens Advisory Council.

MR. JACK CUNNINGHAM: Good afternoon. I'm Jack Cunningham and I'm a consumer representative to the Citizens Advisory Council. I'm also the Chairman of the Governor's Advisory Board at Napa State Hospital and have attempted to fulfill that capacity since 1976. And I am also the current Chairman of the California Organization of State Hospital Chairpersons.

I'm a little more intimidated than I usually am because I will be speaking on behalf of a group of people, a very high functioning organization that encompasses many personalities and many points of views and perspectives, and I will try to discharge that with as much caution and certainly a great deal of enthusiasm if it's possible.

We chose not to write out specific answers in a detailed way to the questions that you had raised and that were so thoughtful in promoting what it is we have to say and what we believe. We assume modestly that that will come out, that those answers, specific and elaborate at the same time, will come out of the work of the small task force, or the task force, the small work groups within the task force.

The Executive Committee of the Council has approved a general statement about the specific issue that we hope you will address within the general realm of involuntary treatment, and we will have the general program statement on the overall mental health delivery system approved, we hope, later this month, and we will submit that to you as promptly as possible.

Before reading you what is the draft of a collective statement, I would, however, like to say something that I think that all of the - well, it's not all of the majority of members of the Council who are distinctive and distinct from each other in many, many ways, nevertheless share - and that is that the term "treatment" as it applies to the mental health system in the communities and the hospitals needs to be looked at very carefully and I'm afraid with a great deal of despair. Because in terms of adequate funding and imagination and completeness of purpose, it barely scratches the surface, not only in terms of equity but in terms of support for mental wellness as well as support for mental health. So in conceptualizing around the term "treatment," please do not for a second believe that we believe that the treatment that is necessary is available.

The Council wishes to go on record as stating to this body that the Council believes that the singlemost important public policy question to be addressed is to what extent should the mental health system be used to hold or control those whose behavior may be unusual or bizarre or even labeled deviant, but is nevertheless within the law? The Council recommends that the Legislature consider the development of a specialized forensic mental health system in which the primary purpose is the protection of the public and in which treatment is given to persons, who because of a mental disorder, are judicially committed or are repeat Penal Code misdemeanor or felony offenders. In considering such a system, serious thought should be given to using state hospitals only for judicially committed persons and sentenced individuals diagnosed as mentally disordered who are in need of this level of care. Any study of the development of the forensic mental health system will need to have as a corollary a study of the existing involuntary treatment system.

That's the formal statement and I would like to add to that in good faith that we believe that LPS needs to continue to be microscopically studied in terms of the language dealing with the treatment of suicidal persons, those who are dangerous to others, persons designated as gravely disabled and those who (quote) need to be involuntarily medicated.

Again, as I said earlier, I believe, and I hope I'm not deviating too far from the general sentiments of the Council, that the problem does not lie intrinsically with LPS. You have heard from a variety of sources today that Californians have a right to be self-congratulatory inasmuch as LPS is a pioneering piece of legislation. As a person who has spent a lot of time in and out of the mental health and state hospital systems, I consider myself in a paradoxically fortunate sort of a way that I was of an age in a place where these tremendous advances have occurred. The problem, if there is a single problem, therefore does not lie with what is after all forward-seeing humane legislation. It lies with the ability of the people who are making decisions around the language of suicidal persons, gravely disabled and so forth, to continue to make quality decisions.



Their ability to perceive carefully and on an individual basis is continually jeopardized by an underfunded system that has built into it almost demonically expectations of magical thinking and magical seeing. So the problem it seems to me, vis-a-vis the individual who may be caught up or about to be caught up in the system, stems from the inability and sometimes, alas, the unwillingness of the people who are responsible for making these words mean something or not mean something in individual cases, who as I have told this very committee before are frequently toxic or fatigued or suffering from a kind of chronic disenchantment with themselves, the system, and certainly the patients, that they become innocently, if you like, but quite destructively a source of even more trouble.

So I do not wish to add my name or voice to the number of people outside the system or within it who want to play ain't it awful. I think it's a very exciting time. I feel sure that you as legislators will take the extensive period of time that you will require if you're going to make any changes to look at all of the things that have been said here and that will continue to be said by people who are directly impacted.

If I could close with a personal note, Mr. Bronzan, I have another life and that is I'm the Director of the Area Agency on Aging for Solano and Napa counties and I've had the pleasure of meeting with your father a number of times, and I thought this would probably be my only chance to congratulate you on your choice of a parent and on the excellent upbringing that apparently you've been able to afford him.

CHAIRMAN MCCORQUODALE: Thank you, Jack. Dr. Washington?

DR. DEREK WASHINGTON: Thank you, Mr. Chairman. In preparing these assumptions we acted on the basis that some of our responses were only valid if certain others were accepted. The major underlying point is that now under LPS the initial question that the Doe v. Gallinot hearing, and that's a hearing conducted after 72 hours have passed, is whether the person should be committed under the LPS criteria. Unfortunately, there is no continuum of care available. If the person is gravely disabled or a danger to self or others, bam! - that person is in the hospital. If he is not he is on the street. A number of our suggestions are based upon the premise that there should be a wider variety of possible intervention modes. I shall try to make this fact clear as I go on through the Mental Health Association positions.

Our responses are to the questions as I will enumerate them. Under the section involuntary commitment criteria, Question 1, as in any situation where one tries to set general criteria which are to cover specific persons, there is no way to make the criteria exactly correct in all instances. Such criteria or guidelines when he determines the ultimate issue. If criteria are laid out in great detail, often persons who probably should be covered by the statute will not be covered. If the criteria are broad, persons not intended to be covered will fit the criteria. This is an area in which there is that interplay of problem with the need for a continuum of care. If a person is close

to the line on needing involuntary intervention, a continuum of care, which could include hospitals, community placements, mandatory out-patient programs, would probably prevent egregious mistakes from being made. Remember, that Mental Health Association has been a long-time supporter of treating the mentally ill in the community.

An example of the type of person who might fall into this grey area is the mentally ill hostile person who constantly comes into an office and pesters and frightens the office receptionist. There is such a person at L.A. Mental Health Association. Such a person probably does not need hospitalization but might well need temporary medications or counseling.

A problem does exist with the LPS criteria interpretation. Different counties or judges within the same county interpret the standards differently. Whether tightening the definition would help is a matter of debate. Perhaps the courts can deal with this problem. What concerns the Mental Health Association is that the elasticity of the standards sometimes appears to be based upon space available in county hospitals and/or the financial needs of the county at that time. Basing the decision of whether to intervene upon such factors is improper from a mental health standpoint.

For Question 2A, there are significant differences between danger and gravely disabled. That difference would be even more significant if the dangerous standard were defined narrowly. And treatment for the two categories might be radically different. People contemplating suicide fall into different groups and treatment for them may be radically different.

Question 2B, the real question is what is the prognosis for the individual and what type of treatment will help? Will hospitalization be effective? If so, then the categorization of the problem is not relevant. Therefore, the answer to A and B is that although there are differences, they are not necessarily determinative. Again, if there were a continuum of care, many of the problems would be lessened.

Three. Although that question can be discussed in great length, the issue which we would like raised is whether being able to provide food, clothing and shelter includes being able to do so with third party help of a friend, community volunteer or even social service agencies. We strongly believe that third party help should be allowed and believe that the statute should so state. Further, if there were a continuum of care, this third party help would come into play relatively often.

For Question 4, there is a definite need to define danger of both to self and others. Evidence and testimony should be taken. Questions to be raised are:

1. How eminent must the danger be?
2. Should the danger be restricted to physical danger?
3. Should there have to be an act? If so, how much danger must be involved?
4. Should threats to others plus the present ability to carry them out be enough?

Remember back to the receptionist threatener. He is becoming prevalent these days. If there were a continuum of care, could the definition of danger be less restrictive because the intrusion would be less severe?

Under Section B, incompetent issues, here we get into an area that needs research to see where this term is used elsewhere. I remember that it is used with regard to informed consent for operations and the like, as was mentioned earlier in the instance of the person who may need to have a leg amputated and give consent for that. It is also used for persons who are so far gone that they cannot cooperate with counsel or help in their own defense. They are then incompetent to stand trial on criminal charges. The questions in this section beg for more information than we have. We should skip it.

Under Section C, procedures, again, the issue is prognosis and best treatment, not category. Should there be involuntary intervention, again, it might be less repugnant to the liberty oriented if the care continuum were available.

Nine. Because of overburdened staff, budget cutbacks and other reasons, the public guardian's office often cannot do a proper job. One model system which might be examined would be the system utilized in Kansas where there are one-to-one volunteers who act as conservators of the person but not the estate. The program has certain similarities to COMPEER<sup>?</sup> - the program which came from the Old Community Friends Program and involves a large number of volunteers. It could be administered under the public guardian's office or some other way. Right now the conservatorships do not seem to be promoting the concept of individualized care.

Ten. Again, the Kansas model is a possibility here. It could be considered for anyone who is eligible for a temporary conservatorship or for any type of involuntary commitment.

For Question 12, again, we go back to the continuum of care as an issue there. And that's the sum of my testimony.

CHAIRMAN MCCORQUODALE: All right, thank you. We appreciate your coming and taking part today. That completes the panel. We had several people who had indicated they would like to make some comments and we will allow some time to do that. I would like to urge that they keep their comments within the framework of whether there is a need to review the Lanterman-Petris-Short Act and suggestions related to that. We'll call on Dr. Craddock first.

DR. CHARLES CRADDOCK: This will be a 2½ minute statement and I appreciate the opportunity to speak to the panel. I am reserving my comments specifically to the question of the mentally ill homeless which in my opinion and that of many of the speakers this morning is an area which is in great need of reassessment under the LPS law.

I am not a psychiatrist. I am an M.D. I take care of patients who have serious and irreversible cancer and leukemia. These people require and are often able to live fruitful and sometimes very surprisingly prolonged life under good medical supervision.

It requires their cooperation and that is the issue that is so different with respect to mental disease of a serious nature. These people by definition often deny that they are ill and blame their difficulties on others. Therefore, they are not amenable to a long-term treatment, either in or out of hospitals, or by professionals of any kind. There is no curage<sup>?</sup> of treatment. That does not mean that they cannot live for a long time fruitfully, just as a diabetic lives for a long time even though he is not cured.

I have a daughter somewhat like the one that a former speaker mentioned who is now 36. She has been psychotic for 18 years. Under LPS no therapy of any sort other than very transient therapy has been available to her. She is now a street person. She's a bag woman, or whatever definition you might wish to give. I don't know where she is. She is lost. And I consider her lost in part related to LPS law because under no circumstances as long as that woman has denied her illness has any form of therapy of any sort mentioned here been available to her.

Thank you very much.

CHAIRMAN MCCORQUODALE: Thank you, Dr. Craddock. Dr. Allen?

DR. CHARLES ALLEN: Thank you for your nobility and hanging in. I can make this brief.

I believe that Section 5008 defining grave disability should have one word added to the definition, namely "self-preservation." I hope that that would encompass some of the things that Mrs. Teisher asked to be added. The reason for this is that the suicide commitments are not adequate to take care of many of the people who are chronically mentally ill. They endanger themselves seriously, continuously, habitually some of them, without intending to do so. But because of the mental illness they fail to seek help when physically ill. They disregard traffic hazards, they're unable to protect themselves from interpersonal violence and may sometimes by peculiar behavior elicit violent responses. The courts interpret the section on grave disability very, very literally and even minimal ability to provide food, clothing and shelter is considered sufficient to deny conservatorship. And this is a very, very discouraging event for everybody who's concerned with the well-being of people. I believe adding this word will not increase the number of admissions to state hospitals, because state hospitals would really like to have adequate supervision in the community. And if there was adequate supervision, we believe that the revolving door would be less, that the people who need the care would at least be screened for what their long-term needs are.

The other main thrust of my piece of paper here is in reference to security at the state hospitals. I believe that there should be a substantial section in each of the state hospitals - Metropolitan, Camarillo and Napa - that have security the equivalent of Atascadero. Atascadero is now caring mainly for mentally ill Penal Code and prison inmates. Atascadero used to be the safety valve for the state hospitals when they had patients so violent they couldn't handle them in their relatively open situation.

Atascadero no longer provides that service. State hospitals then have violent people in an open setting, and the district attorneys do not like to prosecute patients for crimes. It doesn't enhance their record of convictions when not guilty by reason of insanity is the outcome, and they think that a person in a state hospital is already being cared for so why expend the funds. But I feel that every major crime and many of the continual crimes committed by patients on staff and on other patients in state hospitals should be prosecuted to a Penal Code commitment, and that that's not excessive because it at least labels that person as having been an offender in the criminal meaning of the word. And where they're cared for is now being handled by having--Vacaville is a medical facility, Atascadero is a really very secure mental health facility and it was really quite discouraging to hear that the Governor vetoed the additional mental health facility because it's sorely needed.

Thank you very much.

CHAIRMAN MCCORQUODALE: Thank you. Wanda Covington?

MS. WANDA COVINGTON: I didn't realize when I submitted the written testimony that I would be coming up here, but I'm happy for the opportunity.

My son became ill four years ago and the first year that he was home from the service we realized that he needed help, and we did not know how to go about getting help. We checked with a psychiatrist and with doctors and we learned that unless he was a danger to himself or to others or gravely disabled that we could not do anything. So for a year he stayed in our home. He was unable to get a job and we watched him deteriorate. He started standing up in the dark, getting up in the middle of the night, turning over couches, not sleeping all night. He didn't threaten us, he didn't do anything that would have us, or cause us to have him involuntarily committed. He finally started carrying a gun. He carried a gun with him to school, he put it on his pillow and finally it got to the point that he did threaten us. We went through this so-called process that's supposed to--that people should only have to go through once. The sheriff's office came to our house, the crisis units came to our house; they ran out, they had to chase our son, grovel with him, handcuff him and take him to a mental health institution. He was there for 72 hours and released. He was on medication and he was okay. We went through this process three times and each time he could have killed somebody else or hurt us. He was diagnosed as a paranoid schizophrenic and he was put on medication that did have severe side effects. And that was one of the problems - he didn't want to take the medication. The last time that we had him committed he had gotten ahold of a rifle, had sawed it off and was carrying it in his guitar case. The doctor we talked to told us, "Do not turn him in, he may do something to you." This was a private psychiatrist. "Have the mental health institution take care of this." Well, that's almost impossible to do. You have to say something to somebody to have him picked up. Well, luckily, we had him picked up and he was kept this time for a period of four weeks, and the doctor

talked to him and told him that he would not get anymore money, he would not get anymore help if he didn't stay on his medication, and he had been stabilized long enough that he was rational. In fact, he talked to me and he said, "Mom, I don't even know what got into my head." He said, "All these strange things were happening."

So what I believe is wrong with the law is there should be something put in it - and I don't know how to say this exactly - but something should be put in the law to say that a person should be, when he is involuntarily committed, he should be kept long enough to be stabilized on the medication so that he won't have these return bouts back, back, back, back. It's hard on the family, it's hard on us. I'm a member of a group that we've all experienced similar stories. I was never physically abused but there are members in our group that have been abused by their loved ones, and this shouldn't be. He experienced mental torment, he has cried, he has sweated, he was in fear for his life because he was having delusions, he was having hallucinations and there wasn't really anything that the psychiatrist could do about it or we could do about it.

And that's all I've got to say.

CHAIRMAN MCCORQUODALE: All right, thank you. I think we've run out of our time, and we would like to urge that if you do have comments that you would like to make that you could still submit those to us until the 15th of October and they'll be included in the record. We do intend to have other hearings as I indicated earlier. Both Mr. Bronzan and I are well familiar with the saying that, "Fools rush in where angels fear to tread," and so we're not rushing in to make wholesale changes in the law. But we would like to encourage a formation of a group of interested people who would talk seriously about the problems that exist today and try to reach some agreement among themselves of the different viewpoints as to what might be a constructive way to go and any changes that might take place. We're willing to work on this as long as necessary and to the extent that we can provide help or assistance or support in trying to reach that accommodation, and we would like to see this informal group of people get together on an ongoing basis to discuss what might be done and what changes might take place.

Again, we appreciate your coming today. Do you have any comments that you want to make?

ASSEMBLYMAN BRONZAN: Just one. As a housekeeping matter I'd like to thank Mike Desrys and Mike Orozco for the filming of this. They have videotaped this hearing as they have all the hearings of the select committee and they're available to the public for free. If you want a copy, just contact us and we'll get you a copy for whatever purposes you have.

Echoing your comments, Mr. Chairman, this may be the first major discussion on LPS in a while; it certainly isn't going to be the last. Clearly you have competing problems involved here, not the least of which is when is it too much and when is it not enough and when do those needs run into each other? The issue of just how far the state

should involve itself in helping somebody is an issue that is not resolved and is not resolved in my own mind. And I think we're not witnessing an onslaught on the LPS Act, but I think we are witnessing a valid question that was raised in the very first--Senator Short's comments, and that is does a person have a right to treatment - is that one of the rights that a person has. And we haven't solved that in today's hearing and we won't solve it for a while, but I think it's worthy of us bringing attention to as we look at the whole overall problem.

I would just say, Mr. Chairman, that, again, it's striking to me that what dominated much of today's hearing is what has dominated much of all the hearings and that is just how little is being done in general in mental health in the State of California and how much we have to do to debase and how much legal problems like this are affected by it.

CHAIRMAN MCCORQUODALE: All right, fine. Thank you. The meeting is adjourned.

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## GLOSSARY

1. "L-P-S" -- The Lanterman-Petris-Short Act. Enacted in 1969 this statute replaced the old system of indefinite civil commitments for involuntary psychiatric treatment.
2. Short-Doyle -- Enacted in 1957, these statutes establish the state-county organization through which approximately \$400 million is spent each year for the provision of community mental health services.
3. "5150" -- The code section which allows a person to be held involuntarily for up to 72 hours for psychiatric evaluation and/or treatment if he or she is a danger to self, a danger to others or are gravely disabled.
4. Danger to Self -- One of three criteria for involuntary treatment. Generally, this condition is considered to exist if a person has demonstrated suicidal symptoms, as a product of his or her mental disorder.
5. Danger to Others -- One of three criteria for involuntary treatment. Generally, this condition is considered to exist if a person has threatened or assaulted another person due to his or her mental disorder.
6. Gravely Disabled -- One of three criteria for involuntary treatment. The statute defines it as "a condition in which a person, as a result of a mental disorder, is unable to provide for his basic personal needs for food, clothing, or shelter".
7. Competency -- Generally a test for capacity to make certain decisions. Within L-P-S, the capacity at issue is the person's ability to make treatment decisions as a result of his or her mental disorder.
8. Doe v. Gallinot -- the court decision in 1979 which resulted in the requirement that certification review hearings be held after the first 72 hours in order to assess whether there is sufficient "probable cause" to authorize up to 14 more days of involuntary treatment.
9. Jamison v. Farabee -- the court decision in 1982 which resulted in specific hearings to evaluate an involuntary patient's right to refuse psychotropic medications.

10. In re Roger S. -- the court decision in 1977 which found that minors could be involuntarily treated if a mental disorder was present and if they would be likely to benefit from treatment.

11. In re Michael T. -- the court decision in 1982 which found that juvenile courts do not have the authority to involuntarily place minors who are dependents (dependent, neglected, or abused) in secure treatment facilities. Such placement can only be done through L-P-S proceedings.

12. Conservatorship -- A decision by a court to appoint another person to be responsible for most decisions affecting an involuntary patient's life.

13. Temporary Conservatorship -- Appointment of a conservator for up to 30 days.

14. Habeas Corpus -- a writ petitioning for immediate release which can be filed by, or on behalf of, an involuntary patient.

15. "Parens Patriae" -- the specific power of the state on behalf of society to protect and care for those who are considered not capable of caring for themselves.