Mental Health Professionals as Civil Commitment Hearing Officers: Procedural Due Process Problems

Current California statutory law provides that mental health professionals, as hearing officers, may determine whether probable cause exists to commit an allegedly mentally disordered person for fourteen days. This Comment identifies problems that are likely to result from the use of mental health professionals as hearing officers. It examines how the use of psychiatrists as hearing officers may deprive a committed person of procedural due process guarantees by divesting her of the opportunity to be heard by a neutral and detached decisionmaker. Finally, it proposes an amendment to California's Lanterman-Petris-Short Act as a solution to this problem.

INTRODUCTION

Under recent legislation,[1] a certification review hearing must be held if a person is to be involuntarily detained in a California mental health facility for more than seventy-two hours. This legislation, section 5256.1 of California's Welfare and Institutions Code,[2] allows mental health professionals[3] to serve as hearing officers. Such an allowance, however, may not take into account the biases of certain mental health professionals that may affect their ability to serve as impartial hearing officers. This Comment examines the effectiveness of mental health professionals as certification review hearing officers.[4]

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[1] *See* 1982 Cal. Stat. 1598; *infra* notes 17-37 and accompanying text.

[2] CAL. WELF. & INST. CODE § 5256.1 (West Supp. 1984).

[3] *See infra* notes 28-31 and accompanying text.

[4] This Comment does not address the issues involved in using other persons listed in the statute as eligible certification review hearing officers. Because the other professionals do not have mental health backgrounds, there appears to be no question as to their impartiality in serving in this capacity.

The ability of mental health professionals to aid their patients is not questioned. Rather, the effect of their training and experience on their ability to function as impartial certification review hearing officers is addressed.

Two different views of civil commitment influence what legal constraints should apply to decisions to involuntarily confine persons in mental health facilities. People who

Part I of this Comment is an overview of involuntary civil commitment procedures in California. Part II examines whether the use of mental health professionals as hearing officers complies with procedural due process guarantees of the fourteenth amendment to the United States Constitution[5] by balancing three factors. First, the severe deprivation of liberty at stake in civil commitments is discussed. Second, the substantial risk that persons would be erroneously confined by psychiatrist hearing officers because of their biases toward perceiving the presence of both mental disorders and dangerousness when they are in fact absent is analyzed. Third, the lack of any state interest in having psychiatrists perform this function is examined. A balancing of these factors indicates that the use of certain mental health professionals as hearing officers could well deprive involuntarily committed persons of minimal procedural due process protections.

Part II also examines which mental health professional groups present procedural due process problems when they serve as hearing officers. While studies have evaluated the biases of psychiatrists as well as the validity of their commitment judgments, similar attributes of other mental health professionals have rarely been measured. There-

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value civil liberties are primarily concerned with the wrongful confinement of persons. *See* Ellis, *Volunteering Children: Parental Commitment of Minors to Mental Institutions*, 62 CALIF. L. REV. 840, 843 (1974). Some have even advocated the abolition of involuntary commitment. *See, e.g.*, Roth, Dayley & Lerner, *Into the Abyss: Psychiatric Reliability and Emergency Commitment Statutes*, 13 SANTA CLARA LAW. 400, 402 (1973) (urging abolition of involuntary incarceration grounded on label of mental illness due to unreliability of diagnoses of mental illness). On the other hand, people with a medical perspective want the authority to confine persons for treatment when they perceive that it is necessary, and fear that impediments in commitment procedures will interfere with the therapeutic process. *See* Ellis, *supra*, at 843. For a contrary view, see Parham v. J.R., 442 U.S. 584, 636 n.22 (1979) (Brennan, J., concurring in part and dissenting in part) (fair hearing may make a child more likely to accept treatment); *see also* O'Connor v. Donaldson, 422 U.S. 563, 585 (1975) (Burger, C.J., concurring) (effective therapy requires that the patient acknowledge illness and cooperate in treatment); *In re* Gault, 387 U.S. 1, 26 (1967) (fairness in appearance may have therapeutic effect in accepting confinement). People have argued that the treatment of the mentally ill is a medical problem and that the purpose of confinement is for rehabilitation, not punishment. *See* Roth, Dayley & Lerner, *supra*, at 415. In the past, these assertions, along with the emphasis on the civil, as opposed to criminal, nature of involuntary commitment proceedings, have justified curtailment of procedural due process protections. *See id.* at 412-16. This Comment does not question the authority of the state to involuntarily confine persons in certain circumstances. It merely urges that minimal procedural due process protections be provided to the person who is being involuntarily detained.

[5] U.S. CONST. amend. XIV, § 1.

fore, a question is raised whether the results of studies involving psychiatrists can be generalized to other mental health professionals. Part II examines the similarities and differences among mental health professions, and shows that results of empirical studies of psychiatrists may be generalized to both nurses and medical doctors but to neither social workers nor psychologists.

Part III explains how the expansion of the use of psychologists and social workers as hearing officers, along with the elimination of psychiatrists, nurses, and medical doctors from this role, is likely to reduce the number of erroneous confinements in California. This Comment concludes by proposing an amendment to section 5256.1 of California's Welfare and Institutions Code which would eliminate psychiatrists, medical doctors, and nurses from the list of eligible certification review hearing officers.

I. Involuntary Civil Commitments in California

A. *Short Term Civil Commitment Criteria Under the Lanterman-Petris-Short Act*

California's major legislation on civil commitments, the Lanterman-Petris-Short Act[6] (LPS Act), provides a comprehensive scheme for both voluntary[7] and involuntary[8] treatment of mentally disordered persons.[9] The Act permits an initial seventy-two hour period of involuntary emergency confinement.[10] At the end of that period, unless the patient

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[6] Cal. Welf. & Inst. Code §§ 5000-5550 (West 1972 & Supp. 1984).

[7] *Id.* § 5003 (West 1972):

> Nothing in this part shall be construed in any way as limiting the right of any person to make voluntary application at any time to any public or private agency or practitioner for mental health services, either by direct application in person, or by referral from any other public or private agency or practitioner.

[8] *See infra* notes 10-16, 38-42 and accompanying text.

[9] The Act also applies to persons impaired by chronic alcoholism and persons who are developmentally disabled. Cal. Welf. & Inst. Code § 5001(a) (West Supp. 1984). This Comment's focus is on the treatment of the mentally ill. It will not discuss the application of the LPS Act to persons who are impaired by chronic alcoholism or persons who are developmentally disabled.

One objective of the LPS Act is to end inappropriate, indefinite, and involuntary commitments. *Id.* Another goal is to provide prompt short-term treatment to persons in need of help. *In re* Chambers, 71 Cal. App. 3d 277, 282, 139 Cal. Rptr. 357, 361 (1st Dist. 1977).

[10] Cal. Welf. & Inst. Code § 5150 (West Supp. 1984). Two criteria must be met for 72 hour commitments. First, there must be probable cause to believe that the person is a danger to herself or others, or gravely disabled. Second, a mental disorder must

consents to treatment, the confining institution must either release her[11] or, through a certification procedure, detain her for an additional fourteen days of involuntary intensive treatment.[12]

Three conditions must be met to detain a person involuntarily for an additional fourteen days. First, the professional staff at the facility detaining the patient must analyze her condition and conclude that she suffers from a mental disorder that causes her to be either dangerous[13] or gravely disabled.[14] Second, the county must have designated the facility to provide intensive treatment, and the institution must agree to admit the patient.[15] Third, the patient must have refused voluntary confinement although advised of the need for treatment.[16]

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cause the disability or dangerousness. *Id.* The LPS Act defines grave disability as the inability to provide for basic personal needs of food, clothing, or shelter. *Id.* § 5008(h)(1). A person is mentally disordered if she suffers from a condition defined as a mental disorder in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. 9 CAL. ADMIN. CODE § 813 (1982).

Persons empowered to determine whether these criteria are met and authorize commitment are peace officers, treatment facility staff members, mobile crises team members, and other designated professionals. The person empowered to authorize confinement initiates involuntary detention by filing a written application. The application must state that the authorizing person has probable cause to believe that the individual meets the criteria set out in § 5150. The applicant must also state the circumstances that brought the allegedly disordered person to her attention. CAL. WELF. & INST. CODE § 5150 (West Supp. 1984).

A person also may be involuntarily committed for 72 hours of evaluation and treatment by either a superior court order, *id.* § 5200 (West 1972), or in response to a petition by any individual, *id.* § 5201.

During the 72 hour detention period there is no provision for a review of the commitment decision. This absence of a review has received criticism. *See* Note, *"Who Says I'm Crazy?" — A Proposal for Mandatory Judicial Review of Emergency Detention in California*, 51 S. CAL. L. REV. 695, 727-29 (1978).

[11] Saturdays, Sundays, and holidays are included in computing the 72 hour period unless the Department of Mental Health certifies that the facility cannot reasonably evaluate and treat persons on those days. CAL. WELF. & INST. CODE § 5151 (West Supp. 1984).

[12] *Id.* §§ 5152, 5250 (West 1972 & Supp. 1984). Section 5152 also permits the elimination of certification by the immediate institution of conservatorship proceedings. *Id.* § 5152 (West 1972).

[13] *Id.* § 5250(a) (West Supp. 1984). To meet the criteria for dangerousness, the patient must be either a danger to herself or to others. *Id.*

[14] *Id.*

[15] *Id.* § 5250(b).

[16] *Id.* § 5250(c).

B. Certification Review Hearings

Until recently, the LPS Act did not provide for mandatory certification review hearings.[17] In 1979, however, a federal district court held

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[17] Prior to the recent amendment to the LPS Act providing certification review hearings, the right to habeas corpus review was available to persons being certified. Certified patients continue to have this right. *Id.* § 5275 (West 1972).

Every person detained by certification has the right to a hearing by a writ of habeas corpus. *Id.* Judicial review must take place if the patient or a person acting on her behalf informs the professional staff at the treatment facility that such review will be sought. *Id.* § 5276. The member of the treatment staff to whom such a request is made must transmit the request to the superior court without delay. *Id.* § 5275. The person requesting to be released must be informed of her right to counsel by both a member of the treatment staff and the court. If the person elects, the court must appoint an attorney to assist the patient in her preparation of a petition for the writ of habeas corpus and to represent her in the proceedings. The court must hold a hearing within two judicial days after the filing of the petition. If any of the criteria for certification are found absent, the court must release the patient. The court may also release the patient without holding a hearing. *Id.* § 5276.

Habeas corpus review presents problems. Placing the burden on the patient to affirmatively seek review is inadequate because a hospitalized patient's initiative is often inhibited. The reason for this inhibition is not hard to understand. The patient may not be able to grasp the difficult concept of habeas corpus. "According to . . . [the] Medical Director of Camarillo State Hospital, approximately 25 percent of the patients certified under § 5250 do not comprehend the explanation of their habeas corpus rights." Doe v. Gallinot, 486 F. Supp. 983, 988 (C.D. Cal. 1979), *aff'd*, 657 F.2d 1017 (9th Cir. 1981). The California Supreme Court has also recognized that certified patients may fail to comprehend their habeas corpus rights. Thorn v. Superior Court, 1 Cal. 3d 666, 674, 464 P.2d 56, 62, 83 Cal. Rptr. 600, 605 (1970) (upholding Superior Court of San Diego County's appointment of a public interest law firm to represent all certified patients).

A number of factors may contribute to this lack of understanding. One important consideration is that the patient often relies solely on the hospital staff for an explanation of personal rights and for access to the superior court. *Gallinot*, 486 F. Supp. at 988. This may present a conflict of interest because the same person responsible for explaining habeas corpus rights to the patient may also be responsible for the certification decision.

Even if a detailed and accurate explanation of habeas corpus is given and understood, the average patient may be unable to initiate proceedings because institutionalization often causes disorientation, *see* Roth, Dayley & Lerner, *supra* note 4, at 421, and apathy, *see* R. PRICE & B. DENNER, THE MAKING OF A MENTAL PATIENT 278-79 (1973). In addition, the patient may be receiving psychotropic drugs. *Gallinot*, 486 F. Supp. at 987; *Thorn*, 1 Cal. 3d at 675, 464 P.2d at 62, 83 Cal. Rptr. at 606. Psychotropic drugs alter thought processes, *see* Roth, Dayley & Lerner, *supra* note 4, at 439, and decrease initiative, *see* Ennis, *Civil Liberties and Mental Illness*, 7 CRIM. L. BULL. 101, 116 (1971) (discussing Thorazine, a frequently used psychotropic drug which reduces initiative). Furthermore, even if the patient manages to request release, the hospital staff may coax her to stay by encouraging her to be cooperative. *See* Roth,

that California's fourteen day certification procedure unconstitutionally violated due process. In *Doe v. Gallinot*,[18] the district court ruled that the state must initiate probable cause[19] hearings for patients who have

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Dayley & Lerner, *supra* note 4, at 422-23.

Another problem with habeas corpus review is that requiring the patient to request a hearing reverses the usual due process procedure. *Gallinot*, 486 F. Supp. at 993. The state is usually obliged to initiate a hearing and justify the deprivation of liberty. *Gallinot*, 657 F.2d at 1023. The requirement that the state initiate a hearing has been recognized in other contexts. *See, e.g.*, Freedman v. Maryland, 380 U.S. 51, 61-62 (1965) (movie censor has burden of instituting judicial proceedings); Stypmann v. City and County of San Francisco, 557 F.2d 1338, 1344 (9th Cir. 1977) (creditor seizing automobile must make showing of probable cause).

Moreover, when a person is deprived of a liberty interest, due process usually requires a hearing prior to the deprivation. Luna v. Van Zandt, 554 F. Supp. 68, 72 (S.D. Tex. 1982); *cf.* Boddie v. Connecticut, 401 U.S. 371, 379 (1979) (right to a hearing before deprivation of a property interest). However, there are extraordinary situations when there is a valid government interest at stake which justifies postponing the hearing. *Luna*, 554 F. Supp. at 72. Accordingly, the initial 72 hours of confinement has been justified as necessary. *Gallinot*, 486 F. Supp. at 993. The state's need to deal quickly with a person who poses a threat to either herself or others outweighs a patient's interest in having a prior hearing. *Luna*, 554 F. Supp. at 72.

Even though commitment is initially permissible, involuntary confinement cannot constitutionally continue after the justification ceases to exist. O'Connor v. Donaldson, 422 U.S. 563, 574-75 (1975). Therefore, emergency commitment should continue only for the length of time necessary to arrange a probable cause hearing. *Luna*, 554 F. Supp. at 73; *Gallinot*, 486 F. Supp. at 993.

Considering the inadequacies of habeas corpus review, providing a fair hearing by a neutral and detached tribunal is very important. The need for a prompt mandatory hearing is self-evident, considering the high risk of error involved in commitment decisions. *Luna*, 554 F. Supp. at 73.

[18] 486 F. Supp. 983 (C.D. Cal. 1979), *aff'd*, 657 F.2d 1017 (9th Cir. 1981). When Officer Gary Gallinot observed John Doe returning to his car in a hospital parking lot, he thought that Mr. Doe appeared very shy and apprehensive. When the officer approached him, John Doe began to run away. The officer followed Mr. Doe and requested identification. John Doe properly identified himself and then began talking about mental telepathy and people dying. After a brief period of time, Mr. Doe was transported in handcuffs to a county mental health facility. After evaluation by a psychiatric nurse, he was involuntarily detained for 72 hours of observation and treatment. The psychiatric nurse concluded that Mr. Doe was gravely disabled and in need of hospitalization because he was confused, delusional, and paranoid.

Following the nurse's evaluation, Mr. Doe was transported in full restraints to Camarillo State Hospital where he was placed in a seclusion room and given a variety of psychotropic drugs. Mr. Doe was certified for an additional fourteen days of treatment for being gravely disabled as a result of a mental disorder. Two weeks after his initial confinement, a superior court judge granted Mr. Doe's petition for habeas corpus, and he was released. 486 F. Supp. at 986-88.

[19] Probable cause has been defined as that which a person of reasonable caution would believe occurred. People v. Miller, 7 Cal. 3d 219, 225, 496 P.2d 1228, 1232, 101

been certified.[20] The exact nature of the required probable cause hearing necessary for certifications was left undecided by *Gallinot*,[21] permitting the state to develop its own method for providing independent certification reviews.[22] In response, the California Legislature enacted Assembly Bill Number 3454,[23] effective January 1, 1983, requiring mandatory probable cause hearings, also referred to as certification re-

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Cal. Rptr. 860, 864 (1972).

[20] 486 F. Supp. at 994. The plaintiff's claim rested solely on the application of the then existing procedure to gravely disabled persons. *Id.* at 992. Thus, the court did not face the question of the constitutionality of the certification procedure as applied to persons allegedly dangerous to themselves or others.

In reaching its decision, the court considered both the severe deprivation of liberty caused by civil confinements and the high risk of error involved in commitment decisions. The court expressly recognized that the then existing habeas corpus scheme provided procedural safeguards but held that they were inadequate. *Id.* at 991-92; *see also supra* note 17.

As the Ninth Circuit recognized in affirming the district court's holding in *Gallinot*, there is a high likelihood that review by an independent decisionmaker would substantially reduce the number of erroneous fourteen day certifications. Doe v. Gallinot, 657 F.2d 1017, 1023 (9th Cir. 1981). Moreover, the requirement of a prompt probable cause hearing does not place an undue burden on the state. *Id.*; Luna v. Van Zandt, 554 F. Supp. 68, 76 (S.D. Tex. 1982). Due process does not require that the decision be made by a judicial officer. *Gallinot*, 486 F. Supp. at 994. Additionally, the state is not required to meet the burden of proof necessary in long term commitments. *Luna*, 554 F. Supp. at 76. Involuntary commitment to a state mental hospital for an indefinite period must be grounded on the intermediate standard of proof of clear and convincing evidence. Addington v. Texas, 441 U.S. 418, 425 (1979). For 14 day certifications, only the standard of probable cause must be met. *Gallinot*, 657 F.2d at 1023.

Other courts have required mandatory probable cause hearings for short term mental health commitments. *See, e.g., Luna*, 554 F. Supp. at 72 (hearing required within 72 hours of initial confinement); Doremus v. Farrell, 407 F. Supp. 509, 515 (D. Neb. 1975) (hearing required within five days of detention); Lynch v. Baxley, 386 F. Supp. 378, 388 (M.D. Ala. 1974) (hearing required within seven days of detention); Bell v. Wayne County Gen. Hosp., 384 F. Supp. 1085, 1097-98 (E.D. Mich. 1974) (hearing required within five days of confinement); Lessard v. Schmidt, 349 F. Supp. 1078 (E.D. Wis. 1972) (judicial hearing required within 48 hours of emergency detention), *vacated and remanded on procedural grounds*, 414 U.S. 473, *new judgment entered*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded*, 421 U.S. 957 (1975) (for consideration in light of Huffman v. Pursue, Ltd., 420 U.S. 592 (1975)), *aff'd on rehearing*, 413 F. Supp. 1318 (E.D. Wis. 1976).

In *Gallinot*, the court also considered the plaintiff's claim that the criteria of gravely disabled as defined in § 5008(h)(1) were unconstitutionally vague. The court held that California's gravely disabled standard was not unconstitutionally vague. *Gallinot*, 486 F. Supp. at 991.

[21] 486 F. Supp. at 994.

[22] *Id.*

[23] 1982 Cal. Stat. 1598.

view hearings, for all fourteen day certifications under the LPS Act.[24]

Two mental health professionals must sign a notice of certification to certify a person.[25] Within four days after the delivery of the notice to the person certified,[26] a hearing must be held to determine whether probable cause exists to detain her.[27] Either a court appointed commissioner, a referee, or a certification review hearing officer may conduct the hearing.[28] A certification review hearing officer can be a state quali-

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[24] CAL. WELF. & INST. CODE § 5256.8 (West Supp. 1984).

[25] For a person to be certified . . . , a notice of certification shall be signed by two people. The first person shall be the professional person, or his or her designee, in charge of the agency or facility providing evaluation services. A designee of the professional person in charge of the agency or facility shall be a physician or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders.

The second person shall be a physician or psychologist who participated in the evaluation. The physician shall be, if possible, a board certified psychiatrist. The psychologist shall be licensed and have at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders.

If the professional person in charge, or his or her designee, is the physician who performed the medical evaluation or a psychologist, the second person to sign may be another physician or psychologist unless one is not available, in which case a social worker or a registered nurse who participated in the evaluation shall sign the notice of certification.

Id. § 5251.

The notice must allege the existence of the conditions for certification as set forth in § 5250. *See id.* §§ 5250, 5252.

[26] The notice must be personally delivered to both the patient and her attorney or advocate. *Id.* § 5253. The LPS Act provides the form for the notification. *Id.* § 5252. The person delivering the notice must inform the patient of her right to habeas corpus review and the right to a certification review hearing to determine probable cause for detention. The patient must also be given an explanation of her hearing rights including the right to the assistance of either an attorney or advocate. *Id.* § 5254.

[27] *Id.* § 5254. The hearing may be postponed for up to 48 hours at the request of the certified person, her attorney, or her advocate. There is no requirement that a mandatory hearing be held if the patient requests judicial review by habeas corpus. *Id.*

[28] Section 5256.1 provides:

The certification review hearing shall be conducted by either a court-appointed commissioner or a refereee, or a certification review hearing officer. The certification review hearing officer shall be either a state qualified administrative law hearing officer, a medical doctor, a licensed psychologist, a registered nurse, a lawyer, a certified law student, or a licensed clinical social worker. Licensed psychologists, licensed clinical social workers, and registered nurses who serve as certification review hearing officers shall have had a minimum of five years experience in mental health. Certification review hearing officers shall be selected from a list of

fied administrative law hearing officer, a medical doctor, a licensed psychologist, a registered nurse, a lawyer, a certified law student, or a licensed clinical social worker.[29] Psychiatrists also may serve as hearing officers because, although not expressly listed as eligible hearing officers, they are medical doctors.[30] Licensed clinical social workers, licensed psychologists, and registered nurses must have a minimum of five years experience in mental health to qualify as hearing officers.[31]

Certification review hearings must be conducted[32] at the confining facility,[33] and the patient must be present unless she waives this right.[34] In addition, a patient possesses certain rights to insure fairness at the hearing, including the right to the assistance of an attorney or advocate.[35] For the involuntary confinement to continue, the hearing officer

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> eligible persons unanimously approved by a panel composed of the local mental health director, the county public defender, and the county counsel or district attorney designated by the county board of supervisors. No employee of the county mental health program or of any facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation may serve as a certification review hearing officer.

Id. § 5256.1.

[29] *Id.*

[30] *See* Ludwig & Othmer, *The Medical Basis of Psychiatry*, 134 AM. J. PSYCHIATRY 1087 (1977).

[31] CAL. WELF. & INST. CODE § 5256.1 (West Supp. 1984).

[32] Certification review hearings must be conducted in an informal manner. *Id.* § 5256.4(b).

[33] *Id.* § 5256.1.

[34] *Id.* § 5256.3. Effective waiver requires that the patient waive with the assistance of her attorney or advocate. *Id.*

[35] An attorney or advocate must meet with the patient to help her prepare for the hearing, and the patient has the right to the assistance of an attorney or advocate at the hearing. *Id.* §§ 5255, 5256.4(a)(1). In addition, she has the right to present evidence on her own behalf and question persons offering evidence in support of certification. *Id.* § 5256.4(a)(2), (3). Furthermore, the patient may make reasonable requests for the attendance of facility employees who have knowledge of the certification decision, and if the patient has received medication within 24 hours prior to the hearing, the hearing officer must be notified of that fact and probable side effects of the medication. *Id.* § 5256.4(a)(4), (5).

The evidence supporting the certification must be presented by a person designated by the director of the treatment facility. Additionally, either the district attorney or the county counsel may present evidence at her discretion. *Id.* § 5256.2.

The person conducting the hearing is not bound by rules of procedure or evidence applicable in judicial proceedings. *Id.* § 5256.4(b). All evidence which is relevant to establishing that the patient is or is not a danger to others, to herself, or gravely disabled as the result of a mental disorder is admissible. *Id.* § 5256.4(c).

Oral notification of the hearing officer's decision must be given to the patient at the

must find probable cause that the patient is either dangerous or gravely disabled as the result of an existing mental disorder.[36] If the hearing officer does not find probable cause, the involuntary detention must be terminated.[37]

C. Post Certification Provisions Under the LPS Act

The certification period may not last longer than fourteen days,[38] after which the patient must be released, unless she falls within one of the post certification provisions.[39] The LPS Act provides for involuntary detention beyond the certification period in three situations: (1) fourteen day recertification periods for suicidal patients;[40] (2) one hundred-eighty day holding extensions for patients posing a danger of substantial harm to others;[41] and (3) conservatorship appointments for per-

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conclusion of the hearing. In addition, the patient's attorney or advocate must be given a written notification of the decision as soon as is practicable. *Id.* § 5256.7.

[36] *Id.* § 5256.6. If probable cause to involuntarily confine the patient is found, the patient's attorney or advocate must inform her of her right to request release by habeas corpus. *Id.* § 5256.

[37] *Id.* § 5256.5.

[38] *Id.* § 5257. If during the 14 day period the facility finds that the patient no longer meets the certification criteria, it must release her. *Id.* After involuntary commitment has begun, the total period of detention, including intervening periods of voluntary treatment, must not exceed the total maximum period during which the person could have been detained, if the person had been detained continuously on an involuntary basis from the time of initial involuntary commitment. *Id.* § 5258.

[39] *See infra* notes 40-42 and accompanying text.

[40] *Id.* § 5260 (West 1972). Three conditions are required for such involuntary confinement to take place. First, the patient must have a mental disorder which caused her to attempt or threaten to take her life. She must have either been originally confined for such an attempt or threat or the behavior must have occurred during the present hospitalization period. Second, the professional staff of the facility must find that the patient is in imminent danger of taking her own life, but has refused voluntary treatment. Third, the facility must be staffed, equipped, and willing to provide the additional intensive treatment. *Id.* The recertification includes many of the same procedures as the original certification. A notice of certification must be signed by two professionals, *id.* § 5256.1 (West Supp. 1984), with copies delivered to the patient, her attorney, the district attorney, the public defender, the intensive treatment facility, and a person designated by the patient, *see id.* § 5263. The patient has the right to habeas corpus review and the right to counsel. *Id.* §§ 5275, 5276 (West 1972).

[41] *Id.* § 5300 (West Supp. 1984). The patient must have either threatened, attempted, or actually inflicted physical harm on another person during hospitalization, or need have been admitted because of such an act. Also, she must present a demonstrated danger of substantial physical harm to others as a result of a mental disorder. *Id.* The petition to confine the person may be filed in the superior court any time during the 14 day certification period. *Id.* § 5301. The petition must be supported by

sons who remain gravely disabled.[42]

II. The Constitutionality of Mental Health Professionals Serving as Hearing Officers

The United States Supreme Court recognizes the importance of procedural due process in protecting individual freedom.[43] The fourteenth amendment to the United States Constitution[44] protects individual liberty, and the amendment's due process clause prevents arbitrary state action from intruding upon that liberty.[45] Basic procedural protections include the right to be heard in a meaningful manner[46] by a fair and

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affidavits describing the behavior which indicates that the person meets the criteria for 180 day confinements. The patient must be served a copy of the petition on the same day it is filed with the superior court. A filing of a post certification petition triggers a mandatory hearing. *Id.* § 5303 (West 1972). In addition, the patient has the right to request a jury trial. *Id.* § 5302.

[42] *Id.* § 5350 (West Supp. 1984). The purpose of the conservatorship, which places the patient under the care of a court appointee, is to provide individual treatment, supervision, and placement. *Id.* §§ 5350, 5350.1. The conditions necessary for the appointment of a conservator are that the person is gravely disabled and that the disability is a result of a mental disorder. *Id.* § 5350. The patient has the right to request a court or jury trial following a hearing on the petition for the appointment of a conservator. The hearing is automatically waived if the patient demands a trial before the conservatorship hearing. *Id.* If the hearing is not waived, it must be held within 30 days after the filing of the petition. *Id.* § 5365. The LPS Act provides for the appointment of a temporary conservatorship of 30 days to serve until the resolution of the regular conservatorship petition. *Id.* § 5352.1. The patient may seek habeas corpus relief during the temporary conservatorship period. *Id.* § 5353. If a jury trial is requested, the decision to appoint a conservator must be made by a unanimous jury. *In re* Roulet, 23 Cal. 3d 219, 590 P.2d 1, 152 Cal. Rptr. 425 (1979). Also, the decision by either a court or jury must be based on proof beyond a reasonable doubt. *Id.* If the conservatorship is granted, the conservatee may request a rehearing at any time. However, rehearings may not be in excess of every six months. Cal. Welf. & Inst. Code § 5364 (West Supp. 1984). The conservatorship automatically terminates at the end of one year, but the conservator may petition annually for reappointment. *Id.* § 5361. The conservator has the power to place the conservatee in a mental health, nursing home, or medical facility. However, the conservator has an obligation to place the conservatee in the least restrictive alternative setting. *Id.* § 5358.

[43] *In re* Gault, 387 U.S. 1, 19-21 (1967) (procedural due process indispensable in protecting individual liberty at stake in juvenile delinquent proceedings).

[44] U.S. Const. amend. XIV, § 1. The fourteenth amendment provides that a state cannot "deprive any person of life, liberty or property without due process of law." *Id.*

[45] *In re* Gault, 387 U.S. 1, 19-21 (1967). The state action that invokes the fourteenth amendment in 14 day certifications is the enactment of the statutes. Brown v. Jensen, 572 F. Supp. 193, 197 n.1 (D. Colo. 1983) (hospital confinement pursuant to a mental commitment statute constitutes state action).

[46] Mathews v. Eldridge, 424 U.S. 319, 333 (1976) (right to be heard in a meaning-

impartial tribunal.[47]

Under California legislation, a wide array of mental health professionals can act as hearing officers in a certification review hearing.[48] The professionals specifically mentioned include medical doctors, psychologists, registered nurses, and social workers.[49] Psychiatrists are permitted by implication because they are medical doctors.[50] Mental health professionals at first seem appropriate certification review hearing officers because of their backgrounds. Yet, further analysis shows that it is precisely the biases and assumptions cultivated by certain mental health professionals' backgrounds and training which raise questions as to their impartiality.[51] The attitudes of these professionals may render them unsuitable to act as neutral and detached hearing officers. This Part evaluates whether the use of mental health professionals as certification review hearing officers comports with procedural due process guarantees.

A. Supreme Court Decisions

1. Requirements for Procedural Due Process — *Mathews v. Eldridge*

Due process is a flexible concept,[52] and, as a result, the individual and state interests involved in a proceeding must be considered in determining what procedural protections are required.[53] In *Mathews v. Eldridge*,[54] a case which dealt with the termination of social security benefits, the United States Supreme Court announced that satisfying procedural due process requirements depends on three factors.[55] First, the court must consider the nature of the individual interest at stake.

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ful manner prior to termination of Social Security benefits); Armstrong v. Manzo, 380 U.S. 545, 552 (1965) (right of natural father to be heard in a meaningful manner when stepfather petitions for adoption).

[47] Gibson v. Berryhill, 411 U.S. 564, 578-79 (1973) (Board of Optometry so biased that it could not constitutionally conduct optometrists' revocation hearings).

[48] *See supra* notes 28-31 and accompanying text.

[49] *See supra* note 28 and accompanying text.

[50] *See supra* note 30 and accompanying text.

[51] *See infra* notes 115-49 and accompanying text.

[52] Morrissey v. Brewer, 408 U.S. 471, 481 (1972) (flexibility of due process addressed in context of procedures required prior to parole revocation).

[53] *See, e.g.*, Goss v. Lopez, 419 U.S. 565, 579 (1975) (10 day suspension from school impinges on liberty and so requires procedural due process; however, discussion with student and affording student opportunity to explain is sufficient).

[54] 424 U.S. 319 (1976).

[55] *Id.* at 335.

Second, the risk of erroneous deprivation of these interests through the procedures used, and the probable value of additional or substitute procedural safeguards, must be determined. Lastly, the court must take into account the state's interests, including the fiscal and administrative burdens that additional or substitute procedures would entail.[56]

2. Adequacy of Psychiatric Review in Civil Commitment of Minors — *Parham v. J.R.*

Two United States Supreme Court cases, *Parham v. J.R.*[57] and *Vitek v. Jones*,[58] have discussed who may function as decisionmakers in commitment proceedings. In *Parham*, the Court dealt with the procedural protections required when parents or guardians seek institutional mental health care for minors.[59] The Court held that review by a staff physician was constitutionally adequate so long as she was "free to independently evaluate the child's mental and emotional condition and need for treatment."[60] Although the Court acknowledged the fallibility of psychiatric diagnoses,[61] and a minor's substantial liberty interest in

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[56] *Id.* The *Mathews v. Eldridge* balancing approach has been followed repeatedly in determining what procedural due process protections are due. *See, e.g.*, Santosky v. Kramer, 455 U.S. 745, 758-68 (1982) (termination of parental rights requires clear and convincing standard of proof); Parham v. J.R., 442 U.S. 584, 599-600 (1979) (hearing not required for commitment of minors to mental hospital); Addington v. Texas, 441 U.S. 418, 425 (1979) (involuntary commitment for an indefinite period to a state mental hospital requires clear and convincing standard of proof); Smith v. Organization of Foster Families for Equality and Reform, 431 U.S. 816, 848-49 (1977) (hearing not required prior to removing children from foster parents); Luna v. Van Zandt, 554 F. Supp. 68, 74 (S.D. Tex. 1982) (hearing required within 72 hours of involuntary commitment to a mental hospital); Doe v. Gallinot, 486 F. Supp. 983, 992 (C.D. Cal. 1979) (hearing required to confine a person in a mental health facility beyond 72 hour emergency detention period), *aff'd*, 657 F.2d 1017 (9th Cir. 1981).

[57] 442 U.S. 584 (1979).

[58] 445 U.S. 480 (1980).

[59] 442 U.S. at 587. Two minors institutionalized in a Georgia regional hospital filed suit requesting injunctive relief because their due process rights had been violated. Both minors sought placement in a less restrictive environment. *Id.* at 587-90.

[60] *Id.* at 607. The Court stated:

> What is best for a child is an individual medical decision that must be left to the judgment of physicians in each case. We do no more than emphasize that the decision should represent an independent judgment of what the child requires and that all sources of information that are traditionally relied on by physicians and behavioral specialists should be consulted.

Id. at 608.

[61] *Id.* at 609.

avoiding erroneous confinement,[62] it concluded that an adversary proceeding would be inappropriate.[63]

The holding in *Parham* cannot be applied to fourteen day certifications, however, since the situation in *Parham* differs from fourteen day certifications in several respects. Under the LPS Act, the facility itself, as opposed to parents or guardians, is seeking to involuntarily detain the patient.[64] In addition, in *Parham*, the parents' liberty interests were balanced against the minor's own liberty interest in determining the individual interests at stake.[65] The only individual interests at stake in fourteen day certifications are those of the detained patient.[66] Furthermore, the Court in *Parham* was concerned that an adversary hearing might harm the parent-child relationship.[67] There is no such concern when adults are subjected to fourteen day certifications.

In balancing all the interests at stake, the *Parham* Court concluded that a minor's liberty interest could be adequately protected by having

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[62] *Id.* at 600-01.

[63] *Id.* at 609.

[64] *See supra* note 13 and accompanying text.

[65] *Parham*, 442 U.S. at 601-04. The Court has repeatedly recognized parents' broad authority in directing the upbringing of their children. *See, e.g.*, Wisconsin v. Yoder, 406 U.S. 205 (1972) (right of Amish parents to determine proper education for their children); Pierce v. Society of Sisters, 268 U.S. 510 (1925) (right to send children to a private, as opposed to a public, school); Meyer v. Nebraska, 262 U.S. 390 (1923) (right of parents to engage a teacher to teach their children German).

In *Parham*, the Court recognized that parents must have the authority to make decisions about medical care and treatment because most children are unable to make sound judgments about such matters. 442 U.S. at 603. The Court further reasoned that "parents generally do act in the child's best interest." The Court concluded, however, that parents cannot have unreviewable discretion in institutionalizing their child because the child's liberty interest is at stake. The parents' authority to seek such care is subject to physician review. *Id.* at 604. In addressing whether additional procedural protections were due minor wards of the State, the Court held that additional protections were not necessary because the "State acts in the child's best interest." *Id.* at 618.

[66] *See infra* notes 79-92 and accompanying text.

[67] The Court stated:

> Another problem with requiring a formalized, factfinding hearing lies in the danger it poses for significant intrusion into the parent-child relationship. Pitting the parents and child as adversaries often will be at odds with the presumption that parents act in the best interests of their child. It is one thing to require a neutral physician to make a careful review of the parents' decision in order to make sure it is proper from a medical standpoint; it is a wholly different matter to employ an adversary contest to ascertain whether the parents' motivation is consistent with the child's interest.

Parham, 442 U.S. at 610.

a neutral staff physician independently evaluate the parents' commitment decision.[68] However, considering the absence of countervailing parental interests, greater procedural due process protection is warranted with fourteen day certifications.

3. Review Required Prior to Transferring Prison Inmates to Mental Hospitals — *Vitek v. Jones*

In *Vitek v. Jones*,[69] the Court dealt with the procedural protections necessary before prison inmates can be transferred to mental hospitals.[70] The prison administration's exclusive reliance on the opinions of its own psychologists and physicians, involved in the cases, for transfer decisions[71] violated the inmates' procedural due process rights.[72] In explaining the minimal procedural protections required prior to transferring a prisoner to a mental hospital, the Court did not expressly state that the person reviewing the transfer decision could be a psychiatrist or a psychologist.[73] The Court held that an independent decisionmaker, a person with no prior involvement in the case,[74] was essential,[75] but that the person "conducting the transfer hearing need not come from outside the prison or hospital administration."[76] Thus, one could con-

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[68] *Id.* at 606-07. For a discussion criticizing *Parham* on the grounds that it failed to provide adequate due process protection, see 25 VILL. L. REV. 537 (1980).

[69] 445 U.S. 480 (1980). Following a robbery conviction, Jones was sentenced to a term of three to nine years in a Nebraska state prison. While in solitary confinement, he set his mattress on fire, and, as a result, was severely burned. After receiving treatment for his burns, he was transferred to a state mental hospital. A suit was filed, in which Jones intervened, challenging the Nebraska procedure for transferring prisoners to mental hospitals. *Id.* at 484.

[70] *Id.* at 482-83.

[71] *Id.* at 491.

[72] *Id.* at 496. In determining that the existing procedures did not comply with procedural due process guarantees, the Court considered the liberty deprivation that occurs when prisoners are transferred to mental hospitals. *Id.* at 491-94. The Court recognized the inmates' liberty interests in avoiding the stigma that results from commitment to a mental hospital and avoiding mandatory behavior modification therapy. *Id.* at 492. The risk of error in making mental health determinations and the state's interest in treating mentally ill patients were also considered. *Id.* at 495. Criminal convictions entitle a state to confine a person, but do not entitle a state to involuntarily confine a prisoner in a mental hospital. *Id.* at 493. The Court also held that Nebraska's transfer statute created a liberty interest entitled to procedural protections. *Id.* at 488-91.

[73] *Id.* at 494-96.

[74] *See* Goldberg v. Kelly, 397 U.S. 254 (1970); *see also* Morrissey v. Brewer, 408 U.S. 471, 486 (1972).

[75] *Vitek*, 445 U.S. at 496.

[76] *Id.* For a discussion and criticism of *Vitek*, see Note, Vitek v. Jones: *Transfer of*

clude from *Vitek* that a psychiatrist or psychologist who had no prior involvement in the case could conduct the transfer hearing.

The holding in *Vitek* should not be applied to fourteen day certifications, however, because prisoners retain only a qualified liberty interest. As the Court stated, "Undoubtedly, a valid criminal conviction and prison sentence extinguish a defendant's right to freedom from confinement."[77] Civilians subjected to involuntary commitment by the fourteen day certification procedure retain all liberty interests including the right to be free from physical confinement. Because a greater deprivation of liberty is at stake, greater procedural protection should be given to persons subjected to fourteen day certifications than is given to prison inmates.

B. Factors in Determining Whether Minimal Procedural Due Process Guarantees Are Met When Mental Health Professionals Serve as Hearing Officers

Further inquiry is needed to determine whether the use of mental health professionals as certification review hearing officers complies with procedural due process guarantees because the circumstances present in both *Parham* and *Vitek* are different from those present in fourteen day certifications. This determination requires consideration of the following factors: (1) the nature of the personal liberty interests at stake in involuntarily confining persons; (2) the risk of erroneous confinement caused by having various mental health professionals function as hearing officers, and whether excluding them from the list of eligible hearing officers would reduce erroneous confinements; and (3) the legitimate state interests in having mental health professionals serve as certification review hearing officers.[78] Each of these factors will be discussed separately.

1. Personal Interests at Stake in Involuntary Confinements

Confinement in a mental health facility impinges upon liberty interests protected by the due process clause of the fourteenth amendment.[79]

Prisoners to Mental Institutions, 8 AM. J. L. & MED. 175 (1982).

[77] *Vitek*, 445 U.S. at 493; *see also* Price v. Johnston, 334 U.S. 266, 285 (1948) ("[l]awful incarceration brings about the necessary withdrawal or limitation of many privileges and rights").

[78] *See supra* notes 54-56 and accompanying text.

[79] Vitek v. Jones, 445 U.S. 480, 490-92 (1980); Addington v. Texas, 441 U.S. 418, 425 (1979); O'Connor v. Donaldson, 422 U.S. 563, 580 (1975); Doe v. Gallinot, 657 F.2d 1017, 1021 (9th Cir. 1981).

Courts have recognized that a person's interest in avoiding confinement in a mental hospital is very strong,[80] because it results in a "massive curtailment of liberty."[81] A hospitalized patient may be subjected to various forms of physical restraint. For example, she may be placed in a locked psychiatric unit, in a seclusion room, or in mechanical restraints which anchor her to a bed.[82] She may also be subjected to intrusive treatment such as the forced administration of psychotropic drugs,[83] and physical examinations[84] which may violate her rights to privacy and bodily integrity.[85]

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[80] Parham v. J.R., 442 U.S. 584, 600 (1979) (children as well as adults have a substantial liberty interest in not being confined); Luna v. Van Zandt, 554 F. Supp. 68, 74 (S.D. Tex. 1982) (private interest in avoiding confinement is powerful).

[81] Humphrey v. Cady, 405 U.S. 504, 509 (1972); *see also* Parham v. J.R., 442 U.S. 584, 622 (1979) (Stewart, J., concurring); Doe v. Gallinot, 657 F.2d 1017, 1021 (9th Cir. 1981).

[82] *See* Ferleger, *Loosing the Chains: In-Hospital Civil Liberties of Mental Patients*, 13 SANTA CLARA LAW. 447, 483, 487-88, 493-95 (1973); *see also* Doe v. Gallinot, 486 F. Supp. 983, 986-88 (C.D. Cal. 1979), *aff'd*, 657 F.2d 1017 (9th Cir. 1981).

It is not necessary that the patient threaten, attempt, or actually commit a crime to be placed in a locked unit. The patient may be put there because the staff is worried, angry, or uncomfortable with her. Ferleger, *supra*, at 493-95. Patients may be placed in a seclusion room for a variety of reasons including being verbally hostile, screaming, hallucinating, and upsetting other patients. *Id.* at 485. Ferleger described seclusion rooms in one facility as "rooms . . . not large and contain[ing] nothing but a thin mat about thirty inches wide which lies on the tiled floor." *Id.* at 483.

[83] *See* Parham v. J.R., 442 U.S. 584, 626 (1979) (Brennan, J., concurring in part and dissenting in part); Doe v. Gallinot, 486 F. Supp. 983, 992 (C.D. Cal. 1979), *aff'd*, 657 F.2d 1017 (9th Cir. 1981). Psychotropic drugs have harmful side effects and alter thought processes. *See supra* note 17. The administration of medication not only has intrusive effects, it also may be administered in intrusive ways. Roth, Dayley & Lerner, *supra* note 4, at 418 n.70 (medication administered by needle).

The right of a patient who is involuntarily confined in a mental health facility to refuse psychotropic drugs is not clear. For a recent discussion of this point, see Comment, *Involuntary Commitment and the Right to Refuse Treatment With Anti-Psychotic Drugs*, 16 CREIGHTON L. REV. 719 (1983); *see also* Comment, *The Scope of the Involuntarily Committed Mental Patient's Right to Refuse Treatment With Psychotropic Drugs: An Analysis of the Least Restrictive Alternative Doctrine*, 28 VILL. L. REV. 101 (1982). For a recent case addressing this issue, see Rennie v. Klein, 720 F.2d 266 (3d Cir. 1983).

[84] *See, e.g.*, Rosenhan, *On Being Sane in Insane Places*, 13 SANTA CLARA LAW. 379, 395 (1973) (patient's hygiene and waste evacuation often monitored); Roth, Dayley & Lerner, *supra* note 4, at 418 n.66 (patient subjected to a nude examination with many staff members in room).

[85] Parham v. J.R., 442 U.S. 584, 626 (1979) (Brennan, J., concurring in part and dissenting in part); Doe v. Gallinot, 486 F. Supp. 983, 992 (C.D. Cal. 1979), *aff'd*, 657 F.2d 1017 (9th Cir. 1981).

Physical restraint is not the only deprivation of the patient's liberty. Stigmatization often results from treatment in a mental hospital.[86] This stigmatization could result in the loss of family and friends,[87] impose barriers to finding employment,[88] and substantially affect the patient's liberty.

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[86] Vitek v. Jones, 445 U.S. 480, 491-92 (1980); Parham v. J.R., 442 U.S. 584, 600 (1979); Addington v. Texas, 441 U.S. 418, 425-26 (1979); Doe v. Gallinot, 657 F.2d 1017, 1022 (9th Cir. 1981); *see also* B. ENNIS, PRISONERS OF PSYCHIATRY 143-76 (1972); *Developments in the Law — Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1200 (1974) [hereafter *Civil Commitment*].

[87] *See* Parham v. J.R., 442 U.S. 584, 626 (1979) (Brennan, J., concurring in part and dissenting in part); *see also* Tieger & Kresser, *Civil Commitment in California: A Defense Perspective on the Operation of the Lanterman-Petris-Short Act*, 28 HASTINGS L.J. 1407, 1414 (1977) (involuntarily confined persons are often estranged from family and friends).

Hospitalization may burden a patient's personal relationships in other ways. *See, e.g.*, Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1108, 1158-61 (1972) (discusses burden on freedom of association and travel); Roth, Dayley & Lerner, *supra* note 4, at 434 (civil commitment violates freedom of travel and freedom of association); Note, *supra* note 10, at 719-20 (association with family and friends severely limited by hospital visiting procedures).

[88] B. ENNIS, PRISONERS OF PSYCHIATRY 143 (1972) (employers are more willing to hire an ex-convict than an ex-mental patient); THE DILEMMA OF MENTAL COMMITMENTS IN CALIFORNIA, SUBCOMM. ON MENTAL HEALTH SERVICES, CAL. ASSEMBLY INTERIM COMM. OF WAYS AND MEANS 76 (1966) (quoting D. MILLER & W. DAWSON, WORLDS THAT FAIL (Cal. Mental Health Research Monograph No. 7, Cal. Dep't of Mental Hygiene (Sept. 11, 1965)) (only 26% of released mental patients found employment) [hereafter DILEMMA]; Ennis, *supra* note 17, at 110 (even voluntary confinement is an almost complete bar to public employment).

It has been suggested that the real danger of stigmatization results not from confinement as much as from behaving abnormally. Parham v. J.R., 442 U.S. 584, 601 (1979) ("A person needing, but not receiving, appropriate medical care may well face even greater social ostracism resulting from the observable symptoms of an untreated disorder."); *see also* Addington v. Texas, 441 U.S. 418, 429 (1979). However, as recognized by Justice Stewart, the possibility of stigmatization from the abnormal behavior itself does not lessen the individual interest in avoiding confinement. Parham v. J.R., 442 U.S. 584, 622 n.3 (1979) (Stewart, J., concurring) ("The aberrant behavior may disappear, while the fact of past institutionalization lasts forever."); *cf.* Rosenhan, *supra* note 84, at 389. The label of mental illness endures beyond discharge. People develop the expectation that the patient will behave abnormally again. At discharge the patient is viewed as "in remission." Such labels influence the patient, her family, and her friends. Moreover, the diagnosis acts on the patient as a self fulfilling prophecy. After the patient accepts the diagnosis, she behaves according to its expectations. *Id.* Therefore, a person possesses a strong interest in not being improperly or unfairly stigmatized as mentally ill. People v. Burnick, 14 Cal. 3d 306, 321, 535 P.2d 352, 361-62, 121 Cal. Rptr. 488, 497-98 (1975).

Ironically, hospitalization itself may have harmful psychological effects on a patient by damaging her self image,[89] causing further emotional disturbance,[90] or inducing deviant behavior.[91] These harmful effects may occur after only a brief period of detention.[92] As a result, post certification procedural protections may come too late to prevent the harmful psychological effects of erroneous commitments. Considering the severe curtailment of liberty and the harmful psychological impact that may result from even temporary confinement, every reasonable effort should be made to assure that decisions to involuntarily confine people are error free.

2. Risk of Error When Mental Health Professionals Serve as Certification Review Hearing Officers

Basic procedural due process guarantees require that a determination of probable cause for commitment be made by a neutral and detached person.[93] A certification review hearing officer must determine whether there is probable cause to believe that the patient has either a dangerous or gravely disabling mental disorder.[94] Therefore, mental health professionals' impartiality regarding these criteria must be considered to determine the risk of error involved in having them serve as certification review hearing officers.[95]

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[89] Roth, Dayley & Lerner, *supra* note 4, at 416-21.

[90] *Id.* at 435.

[91] *Id.* at 425-27 (hospitalization may cause anxiety, nervousness, suspicion, and agitation).

[92] Lessard v. Schmidt, 349 F. Supp. 1078, 1091 (E.D. Wis. 1972) (even short term confinement in a mental hospital may have long lasting effects on a person's ability to function), *vacated and remanded on procedural grounds*, 414 U.S. 473, *new judgment entered*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded*, 421 U.S. 957 (1975) (for consideration in light of Huffman v. Pursue, Ltd., 420 U.S. 592 (1975)), *aff'd on rehearing*, 413 F. Supp. 1318 (E.D. Wis. 1976).

[93] Luna v. Van Zandt, 554 F. Supp. 68, 76 (S.D. Tex. 1982) (evaluation by a neutral and detached person required for mental institution confinements beyond 72 hours); Miller v. Vitek, 437 F. Supp. 569, 574 (D. Neb. 1977) (neutral and detached hearing body essential for transferring prison inmate to mental hospital), *aff'd sub nom.* Vitek v. Jones, 445 U.S. 480 (1980); *see also* Shadwick v. City of Tampa, 407 U.S. 345, 350 (1972) (practice of municipal court clerks issuing arrest warrants for ordinance violations upheld since no showing of clerks' connection with any law enforcement activity which would distort independent judgment).

[94] CAL. WELF. & INST. CODE § 5256.6 (West Supp. 1984).

[95] One student author has suggested that only judges should determine whether probable cause exists to confine a person in a mental health facility, because probable cause is a legal standard. Note, *supra* note 10, at 710. However, judges are not the sole determiners of legal issues. Lay persons make decisions concerning legal standards in

a. Differences Among the Mental Health Professions that May Affect Their Suitability as Certification Review Hearing Officers

The major mental health professional groups receive different types of training and perform different roles within mental health facilities.[96] As a result, each discipline has distinct attitudes,[97] orientations,[98] and value priorities[99] toward mental illness. Studies of mental health professionals have tended to concentrate on the biases of psychiatrists and the validity of their commitment judgments to the exclusion of other professionals.[100] Consequently, the legitimacy of generalizing findings regarding psychiatrists to other mental health professionals is open to question.

A major point of contention among mental health professionals is their attitude toward the "medical model"[101] approach to mental disor-

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both judicial and administrative contexts. For example, grand juries determine probable cause before issuing indictments and trial juries decide whether guilt is proven beyond a reasonable doubt. Shadwick v. City of Tampa, 407 U.S. 345, 352 (1972). Thus, it is reasonable to allow lay persons to serve as decisionmakers in the certification review setting. Moreover, case law supports the notion that probable cause determinations to civilly confine need not be made by a judicial officer. *See* Doe v. Gallinot, 486 F. Supp. 983, 994 (C.D. Cal. 1979), *aff'd*, 657 F.2d 1017 (9th Cir. 1981). Basic procedural due process guarantees do require, however, that a determination of probable cause for commitment be made by a neutral and detached person. Luna v. Van Zandt, 554 F. Supp. 68, 76 (S.D. Tex. 1982) (evaluation by a neutral and detached person required for mental institution confinements beyond 72 hours); Miller v. Vitek, 437 F. Supp. 569, 574 (D. Neb. 1977) (neutral and detached hearing body essential for prison inmate transfer to mental hospital), *aff'd sub nom.* Vitek v. Jones, 445 U.S. 480 (1980); *see also Shadwick*, 407 U.S. at 350 (upholding practice of municipal court clerks issuing arrest warrants for ordinance violations because there was no showing of clerks' connection with any law enforcement activity which would distort independent judgment).

[96] Foster, McClanahan & Overley, *Mental Health Staff Attitudes as a Function of Experience, Discipline, and Hospital Atmosphere*, 83 J. ABNORMAL PSYCHOLOGY 569, 570 (1974).

Traditionally, physicians diagnosed and treated the patient, psychologists tested the doctors' diagnosis, social workers worked with the patient's relatives and social agencies, and nurses performed custodial and maintenance services for the patient. However, at least in community mental health programs, the tasks presently performed by psychologists, social workers, and psychiatric nurses are the same. Davis & Pattison, *The Psychiatric Nurses' Role Identity*, 79 AM. J. NURSING 298-99 (1979).

[97] Foster, McClanahan & Overley, *supra* note 96, at 570.

[98] *Id.*

[99] Baird, *Social Workers' Orientations Toward Community Health Concepts*, 12 COMMUNITY MENTAL HEALTH J. 275, 276 (1976).

[100] *See infra* notes 115-49 and accompanying text.

[101] The medical model focuses on three concepts: the belief that a pathological pro-

ders. The medical model approach attributes the cause of mental disorders to underlying physical diseases.[102] Psychiatrists, nurses,[103] and medical doctors[104] receive extensive training in the medical model approach, and as a result, are oriented toward its ideology.[105] However, the attitudes of psychologists and social workers reflect a "psychosocial

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cess is occurring and the importance of properly diagnosing the disease, the importance of discovering the cause of the disease and treating it, and the responsibility of the physician in the physician-patient relationship. Ludwig & Othmer, *The Medical Basis of Psychiatry*, 134 AM. J. PSYCHIATRY 1087 (1977).

[102] E. HILGARD, R. ATKINSON & R. ATKINSON, INTRODUCTION TO PSYCHOLOGY 446 (7th ed. 1979); P. ZIMBARDO & F. RUCH, PSYCHOLOGY AND LIFE 289 (brief 9th ed. 1976). According to Zimbardo and Ruch, the main beliefs of the medical model are: (1) abnormal behavior is a symptom of internal pathological states or processes; (2) mental illness is caused by genetic, biochemical, or organic malfunctioning; (3) mental illness is a manifestation of the patient's prior history of trauma, deprivation, and poor mental health care; (4) there are sharp distinctions between "illness" and "health," "abnormal" and "normal," and "sick" and "well"; and (5) treatment involves hospitalization and medical intervention to cure the internal disease. *Id.*

The appropriateness of the medical model has been questioned. E. HILGARD, R. ATKINSON & R. ATKINSON, *supra*, at 446; P. ZIMBARDO & F. RUCH, *supra*, at 289. According to Zimbardo and Ruch, the basic criticisms of the medical model are: (1) mental illness is more properly viewed as deviance than disease; (2) mental illness is not a disease entity but a subjective label applied to some people by others to infer states and processes that are not directly observable; (3) socially, economically, and politically powerless people are more likely to be labeled "mentally ill" than powerful individuals, even if they display identical behaviors; and (4) a mental disorder is the product of a person's interaction with her social environment, with its "conflicting demands, unreasonable rules, and pathological relationships fostered in the family, schools, work, and other situations." *Id.*

[103] Morrison and Nevid administered the Client Attitude Questionnaire to psychologists, social workers, psychiatrists, nurses, and previously hospitalized psychiatric patients. The questionnaire is a 20-item rating scale which measures the degree of endorsement to the psychosocial approach to mental illness, as opposed to the medical model approach. The researchers found that psychologists and social workers were more oriented toward the psychosocial approach than either nurses or psychiatrists. Morrison & Nevid, *Attitudes of Mental Patients and Mental Health Professionals About Mental Illness*, 38 PSYCHOLOGICAL REP. 565, 565-66 (1976).

[104] Morrison, Madrazo-Peterson, Simons and Gold administered a revised version of the Client Attitude Questionnaire to lawyers, physicians, law students, and medical students. The researchers found that physicians had attitudes more favorable to the medical model approach than medical students, lawyers, and law students. Morrison, Madrazo-Peterson, Simons & Gold, *Attitudes Toward Mental Illness: A Conflict Between Students and Professionals*, 41 PSYCHOLOGICAL REP. 1013, 1013-14 (1977).

[105] *See supra* notes 103-04.

approach"[106] toward mental disorders.[107] The psychosocial approach attributes the cause of mental disorders to problems encountered in social and interpersonal interactions.[108]

Mental health professionals also differ in their attitudes toward community mental health.[109] Community mental health centers use several strategies: a focus on a particular population, the prevention of mental disorders, social treatment goals, continuity of care, and total community involvement.[110] Social workers and psychologists tend to have a stronger commitment to community mental health than do either nurses or psychiatrists.[111]

Psychologists' and social workers' attitudes and beliefs differ significantly from those of psychiatrists.[112] Since such differences go to the very origin and proper treatment of mental disorders,[113] psychologists and social workers most likely also differ from psychiatrists in other

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[106] Morrison and Nevid define the "psychosocial" approach to mental illness as the approach identified in the writings of Szasz, Sarbin and Mancuso. Morrison & Nevid, *supra* note 103, at 565. These psychosocial theorists define mental illness as a deviation from norms based on psychosocial, ethical or legal standards. *See* T. SZASZ, IDEOLOGY AND INSANITY 12-24 (1970); *see also* Sarbin & Mancuso, *Failure of a Moral Enterprise: Attitudes of the Public Toward Mental Illness*, 35 J. CONSULTING & CLINICAL PSYCHOLOGY 159, 160-61 (1970). As opposed to attributing an underlying physical illness as the cause of mental illness, the psychosocial theorists attribute problems of daily living encountered in social or interpersonal relations as the cause of mental illness. *See* T. SZASZ, *supra*, at 12-24.

[107] *See supra* note 103.

[108] *See supra* note 106.

[109] *See infra* notes 110-11 and accompanying text.

[110] Langston, *Community Mental Health Centers and Community Mental Health Ideology*, 6 COMMUNITY MENTAL HEALTH J. 387 (1970).

[111] Langston administered the Community Mental Health Ideology Scale to psychiatrists, psychologists, social workers, occupational-recreational therapists, registered nurses, nursing assistants, and secretaries. The Community Mental Health Ideology Scale is a 38-item instrument which measures the degree of agreement or disagreement with community mental health ideology. In comparing the groups, the researcher found that social workers ranked first and psychologists ranked second in community mental health ideology commitment. Nurses ranked fourth and psychiatrists ranked sixth in their agreements with the community mental health movement. *Id.*

Another researcher found that graduate nursing students' commitments to community mental health ideology were closely aligned to those of psychologists and social workers. *See* Baker & Howard, *Mental Health Ideologies of Psychiatric Nurses*, 11 COMMUNITY MENTAL HEALTH J. 195, 201 (1975). However, nursing students are not legally qualified to serve as certification review hearing officers. *See supra* note 28. Registered nurses, who may serve as hearing officers, may not have the same attitudes as those held by nursing students.

For one explanation of psychiatrists' unfavorable attitudes toward the community mental health movement, see Donovan, *Problems of Psychiatric Practice in Community Mental Health Centers*, 139 AM. J. PSYCHIATRY 456 (1982).

[112] *See supra* notes 101-11 and accompanying text.

[113] *See supra* notes 102, 108, 110 and accompanying text.

respects. Therefore, findings of studies measuring the biases or judgment validity rates of psychiatrists should not be generalized to either psychologists or social workers.

Medical doctors' and nurses' beliefs and attitudes, on the other hand, parallel psychiatrists'.[114] For this reason, it is likely that nurses and medical doctors share psychiatrists' biases and judgment validity rates. Scientific studies are needed to clarify this point. However, in the absence of such studies, study results of psychiatrists might be safely generalized to both nurses and medical doctors.

b. Biases of Psychiatrists

Studies indicate that psychiatrists possess certain orientations and biases which make them poorly suited to serve as certification review hearing officers.[115] Since medical school training emphasizes the importance of caution, psychiatrists are more likely to diagnose illness in a healthy person than health in a mentally ill person.[116] Such training seems likely to interfere with a psychiatrist's ability to function as a neutral decisionmaker. In addition, perceptions of illness are affected by personal biases,[117] and there is evidence that psychiatrists have a low tolerance of abnormal behavior[118] which casts further doubt on their ability to function neutrally as certification review hearing officers.

One study showed that psychiatrists are more susceptible than psychologists, law students, and undergraduate students to being influ-

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[114] *See supra* notes 101-11 and accompanying text.

Nurses agree more with community health ideology than do psychiatrists. However, their attitudes do not conflict with those of psychiatrists as sharply as do the attitudes of social workers and psychologists. Nurses' commitments toward community mental health ideology are approximately midway between the commitments of social workers and psychiatrists. *See supra* note 111.

The previously discussed studies do not measure the attitudes of medical doctors toward community mental health. However, both psychiatrists and medical doctors receive medical school training. This common background is an indication that medical doctors may share the biases and judgment validity rates of psychiatrists. For an example of how medical training may affect a person's ability to perform as a neutral hearing officer, see *infra* note 116 and accompanying text.

[115] *See infra* notes 116-49 and accompanying text.

[116] Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CALIF. L. REV. 693, 720-21 (1974); Rosenhan, *supra* note 84, at 385.

[117] Ennis & Litwack, *supra* note 116, at 726-29.

[118] Brown, *Lawyers and Psychiatrists in the Court: Afterword*, 32 MD. L. REV. 36, 39 (1972) (as a group doctors have a much lower tolerance for abnormal behavior than lawyers).

enced by suggestions of their peers that mental illness is present.[119] As a result, psychiatrists may find a mental disorder when in fact it does not exist.[120] A certification review hearing officer must review mental health professionals' determinations that a person is mentally disordered.[121] Therefore, the likelihood of being influenced by prior determinations of mental illness, though no illness exists, indicates that psychiatrists may not be able to make neutral and detached evaluations of patients' conditions in the certification review hearing setting. In sum, the biases and training of psychiatrists make them unsuitable to impartially determine whether probable cause of a mental disorder exists.

c. Risk of Erroneous Confinement When Psychiatrists Serve as Decisionmakers

Courts and commentators recognize the high risk of error inherent in psychiatric judgments.[122] This risk was a major concern in *Doe v. Gal-*

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[119] Temerlin conducted a study in which, after being told by a prestige figure that a person on a tape was psychotic, five groups of subjects heard a tape of the person and then made a diagnosis. Sixty percent of the psychiatrists, 30% of the undergraduates, 28% of psychologists, 17% of the law students, and 11% of the graduate students diagnosed the healthy person on the tape as psychotic. There were four comparable control groups who were not told that the person was psychotic. None of the persons in the control group diagnosed the person as psychotic. Temerlin, *Diagnostic Bias in Community Mental Health*, 6 COMMUNITY MENTAL HEALTH J. 110 (1970).

[120] *Id.*

[121] In order to certify a person, two mental health professionals must sign a notice of certification. CAL. WELF. & INST. CODE § 5251 (West Supp. 1984) (quoted *supra* in note 25). In the notice, the professionals must allege that the person is suffering a mental disorder. *Id.* § 5252. Within four days after the delivery of the notice to the person certified, a hearing must be held to determine whether probable cause exists to detain the person. *Id.* § 5254. Among the decisions the hearing officer must make is a determination of whether probable cause to believe that a person is suffering from a mental disorder exists. *Id.* § 5256.6. Therefore, the hearing officer must review other mental health professionals' allegations that the person is suffering a mental disorder.

[122] *See* Parham v. J.R., 442 U.S. 584, 628-29 (1979) (Brennan, J., concurring in part and dissenting part) (recognizing that even under the best circumstances psychiatric diagnoses are uncertain); Addington v. Texas, 441 U.S. 418, 429 (1979) (recognizing uncertainty and fallibility of psychiatric diagnoses); O'Connor v. Donaldson, 422 U.S. 563, 584 (1975) (Burger, C.J., concurring) (recognizing uncertainty of diagnoses and tentativeness of professional judgments); Luna v. Van Zandt, 554 F. Supp. 68, 74 (S.D. Tex. 1982) (risk of error in all commitment decisions is high); Doe v. Gallinot, 486 F. Supp. 983, 992 (C.D. Cal. 1979) (substantial risk of error in all mental health decisions), *aff'd*, 657 F.2d 1017 (9th Cir. 1981); People v. Burnick, 14 Cal. 3d 306, 326, 535 P.2d 352, 365, 121 Cal. Rptr. 488, 501 (1975) (possibility of mistake in diagnosing mental illness is significantly great); Ennis & Litwack, *supra* note 116, at 694-719 (discussing high risk of error in all psychiatric judgments); Rosenhan, *supra*

linot,[123] which held that mandatory certification review hearings were constitutionally necessary.[124] At issue are both the reliability and validity of psychiatric judgments.[125] Reliability refers to how much psychiatrists agree with each others' conclusions.[126] Validity refers to how accurately their judgments reflect reality.[127]

Empirical studies have shown that psychiatric diagnoses of mental disorders tend to be both unreliable[128] and invalid.[129] In recent years, however, studies show that psychiatrists have made strides in improving the reliability of their diagnoses.[130] These studies indicate only that psy-

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note 84, at 398 (concluding practitioners unable to distinguish the sane from the insane in psychiatric hospitals); Roth, Dayley & Lerner, *supra* note 4, at 402-12 (referring to psychiatry as a nonscience).

[123] 486 F. Supp. 983 (C.D. Cal. 1979), *aff'd*, 657 F.2d 1017 (9th Cir. 1981).

[124] *Id.* at 992.

[125] Ennis & Litwack, *supra* note 116, at 696.

[126] *Id.* at 697-98. Reliability is used to describe accuracy in other contexts. One context is in the area of tests and other measuring instruments. "The reliability of a measuring instrument is the degree to which people earn the same relative scores each time they are measured (aside from changes in them due to health, fatigue, etc.). Reliability is assessed by retesting and by different evaluators scoring the same behavioral event." P. ZIMBARDO & F. RUCH, *supra* note 102, at 273; *see also* E. HILGARD, R. ATKINSON & R. ATKINSON, *supra* note 102, at 348.

[127] Ennis & Litwack, *supra* note 116, at 697. Validity is used to describe accuracy in other contexts. In the context of measuring instruments, "validity is the extent to which an instrument actually measures what it is intended to measure." P. ZIMBARDO & F. RUCH, *supra* note 102, at 273; *see also* E. HILGARD, R. ATKINSON & R. ATKINSON, *supra note* 102, at 349.

[128] *See* Ennis & Litwack, *supra* note 116, at 701-08 and sources cited therein.

[129] *Id.* at 709-11.

[130] One way to improve reliability is to use reference materials which clearly define symptoms and diagnoses. According to the LPS Act, a person is mentally disordered if she suffers from a condition defined as a mental disorder in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). 9 CAL. ADMIN. CODE § 813 (1982). In 1980, the manual was revised. TASK FORCE ON NOMENCLATURE AND STATISTICS, AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS III (DSM-III) (1980). There is evidence of increased diagnostic reliability with DSM-III. *See* Spitzer, Williams & Skodol, *DSM-III: The Major Achievements and an Overview*, 137 AM. J. PSYCHIATRY 151, 154 (1980) (reliability using DSM-III much higher than agreement among clinicians in using DSM-I and DSM-II).

In one study, a two and one-half day training program was conducted to teach mental health professionals how to use DSM-III. The professionals in the study included psychiatrists, psychologists, social workers, and nurses. Following the training program, the professionals diagnosed three cases based on a series of five videotaped case vignettes. Their diagnoses were compared with the consensual diagnoses of the clinical faculty from the Texas Research Institute of Mental Sciences. The percent of

chiatrists now agree more often with each others' conclusions. They fail to measure whether psychiatric judgments are now more valid.[131] In the certification review hearing officer context, measurements of validity are much more significant than calculations of reliability.

One well known study demonstrated that hospital staff members were unable to detect sane "pseudopatients" who were admitted to their hospitals,[132] although other patients were able to detect the

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agreement varied with the different cases. The overall percent of agreement for all cases among the clinical faculty and the professional participants was 74.2%. Webb, Gold, Johnstone & DiClemente, *Accuracy of DSM-III Diagnoses Following a Training Program*, 138 AM. J. PSYCHIATRY 376 (1981).

However, another study found that agreement among psychiatrists was relatively poor for the diagnoses of specific personality disorders. Mellsop, Varghese, Joshua & Hicks, *The Reliability of Axis II of DSM-III*, 139 AM. J. PSYCHIATRY 1360 (1982). In this study, three psychiatrists diagnosed 74 patients over a nine month period. The diagnoses of the three psychiatrists using the DSM-III criteria in everyday clinical settings were compared. The researchers found relatively poor agreement for the diagnoses of specific personality disorders and evidence that the psychiatrists were *biased* toward certain diagnoses. The diagnoses of the presence or absence of a personality disorder was found to be more reliable than the diagnoses of the specific subcategories. *Id.*

One researcher found that there was no significant difference between psychologists' and psychiatrists' perceptions of DSM-III symptom importance. Morey, *Differences Between Psychologists and Psychiatrists in the Use of DSM-III*, 137 AM. J. PSYCHIATRY 1123 (1980). In this study 15 psychologists and 15 psychiatrists were given a shuffled stack of index cards with a DSM-III symptom listed on each card. They were asked to arrange the cards from the lowest to the highest importance that they viewed the symptoms in making a particular diagnosis. The researcher found that a person's profession was not a significant influence in the rating of the symptom importance. She concluded that the results are an indication that when psychologists and psychiatrists operate on a very specific level of evaluation, biases in their different perspectives do not seem to have an effect. *Id.* However, this study does not relate to the hearing context. The problem with psychiatrists as hearing officers is not that they do not know how to rank the importance of symptoms. The problem is that psychiatrists tend to perceive symptoms of a mental disorder when they do not in fact exist. Whether or not psychiatrists and psychologists agree with each other on the importance of symptoms in reaching a diagnosis is irrelevant in evaluating their suitability to serve as certification review hearing officers. The *accuracy* of mental health professionals' judgments and their ability to perceive the *absence* of a mental disorder is important. This study does not measure either of these attributes.

[131] *See supra* note 130. The lack of any measurement of psychiatrists' ability to perceive mental health is particularly significant. *Id.*

[132] Rosenhan, *supra* note 84. In this study, eight persons were admitted to 12 different hospitals. Each patient complained of hearing voices saying "empty," "hollow," and "thud." Immediately upon admission to the psychiatric ward, the patients stopped complaining of any abnormal symptoms and behaved as they would normally behave. Except for alleging the initial symptoms and falsifying information regarding names and

pseudopatients' sanity.[133] All pseudopatients, with the exception of one, were discharged with the diagnosis of "schizophrenia in remission."[134] Yet, none of them were in fact schizophrenic. This experiment demonstrates that validity may be very low while reliability is relatively high.[135] As a result, recent studies[136] showing that psychiatrists' diagnostic reliability has improved should not be viewed as evidence that validity has also improved.

Certification review hearing officers must not only determine whether probable cause of a mental disorder exists. They must also determine whether probable cause exists that the mental disorder causes the patient to be either dangerous or gravely disabled.[137] The fourteen day certification criteria for dangerousness to self or others is not sufficiently precise to avoid risks of error in its application,[138] and

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occupations, the patients were honest about their histories and circumstances. With the exception of one pseudopatient, the staff was not aware of the presence of pseudopatients and the nature of the research project. The length of the pseudopatient hospital stays ranged from seven to 52 days. In order to allow generalization of the findings of the study, the nature of the hospitals that the patients were admitted to varied. *Id.* at 379-84.

For a discussion and criticism of Rosenhan's study which concludes that psychiatrists are able to differentiate the sane from the insane, see Spitzer, *On Pseudoscience in Science, Logic in Remission, and Psychiatric Diagnoses: A Critique of Rosenhan's* "On Being Sane in Insane Places," 84 J. ABNORMAL PSYCHOLOGY 442 (1975). Spitzer criticizes Rosenhan's methodology. It is important to note, however, that Spitzer did not conduct another study using different methodology. His conclusion that psychiatrists are able to differentiate the sane from the insane is not based on empirical data. *See id.*

[133] Rosenhan, *supra* note 84, at 385.

[134] The other patient was diagnosed as a "manic-depressive." *Id.*

[135] Reliability refers to how often psychiatrists agree with each others' conclusions. *See supra* note 126 and accompanying text. Eleven out of 12 of the psychiatrists at the 12 different hospitals diagnosed the pseudopatients as "schizophrenic," *see supra* note 134 and accompanying text, which demonstrates a relatively high level of reliability among the psychiatrists.

[136] *See supra* note 130. Validity refers to how accurate psychiatrists' judgments are in reflecting reality. *See supra* note 127 and accompanying text. None of the pseudopatients were in fact schizophrenic. Thus, the validity of the psychiatrists' judgments was very low while the reliability was relatively high.

[137] CAL. WELF. & INST. CODE § 5256.6 (West Supp. 1984).

[138] *Id.* § 5250. Post certification criteria for involuntary commitments based on these two conditions are much more precise, which leaves less room for erroneous application. *See id.* §§ 5260, 5300 (West 1972 & Supp. 1984). The 14 day certification provision does not define the criteria for dangerousness to others. *Id.* § 5250 (West Supp. 1984). However, post certification hospitalization for dangerousness to others requires that the person have either attempted, inflicted, or made a substantial threat of physical harm upon the person of another. The person must have exhibited that behavior either after having been placed in confinement, or must have attempted or inflicted physical

the validity of psychiatric judgments in this area is notably low.[139] Stud-

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harm upon another person prior to confinement which resulted in her detention. Also, the person must present a demonstrated danger of substantial physical harm to others. *Id.* § 5300.

The criteria for 14 day certifications for dangerousness to self is also undefined. *Id.* § 5250. However, recertification for dangerousness to self requires a finding that the person have either threatened or attempted to take her own life. The patient must have exhibited that behavior either prior to the involuntary detention which resulted in her present confinement or during the time of detention. In addition, the person must continue to present an imminent threat of taking her own life. *Id.* § 5260 (West 1972).

Both 14 day dangerousness standards imply that something less than their post certification criteria would satisfy confinement. This gives a great deal of discretion to both doctors and hearing officers. For example, one author has described a case in which a person was certified as being a danger to himself after a 72 hour detention period. The basis of the certification was that the person was so provocative that the psychiatrist feared that other patients would injure him. The patient would not have met post certification criteria because he never attempted or threatened to harm himself. Tieger & Kresser, *supra* note 87, at 1421 n.58.

A discussion of whether 14 day certification criteria should be more precise is beyond the scope of this Comment. For a recent discussion of commitment criteria, see Dix, *Major Current Issues Concerning Commitment Criteria*, 45 LAW & CONTEMP. PROBS. 137 (1982).

[139] People v. Burnick, 14 Cal. 3d 306, 326-32, 535 P.2d 352, 365-69, 121 Cal. Rptr. 488, 501-05 (1975); Dershowitz, *The Psychiatrist's Power in Civil Commitment: A Knife That Cuts Both Ways*, PSYCHOLOGY TODAY, Feb. 1969, at 43, 47; Ennis & Litwack, *supra* note 116, at 711-16 and sources cited therein.

Two researchers conducted a three year longitudinal study of specific psychiatric predictions of dangerousness. A New York law required a determination of dangerousness for all indicted felony defendants found incompetent to stand trial. Determinations of dangerousness were judicial decisions based on testimony of two psychiatrists. A group of 257 defendants were followed by the researchers. Psychiatrists evaluated 154 defendants as dangerous. Follow up information on the defendants' assaultiveness was derived from: (1) the hospitals where both groups were initially sent; (2) records from hospital readmissions; (3) subsequent hospitalization records; and (4) subsequent arrest records. Based on a three year follow up period, the researchers found that the patients that psychiatrists evaluated as dangerous were not more dangerous than those evaluated as not dangerous. Cocozza & Steadman, *Prediction in Psychiatry: An Example of Misplaced Confidence in Experts*, 25 SOC. PROBS. 265 (1978).

However, researchers who conducted another study concluded that "short term clinical predictions of dangerousness predict assaultiveness in the hospital to a significant degree." Rofman, Askinazi & Fant, *The Prediction of Dangerous Behavior in Emergency Civil Commitment*, 137 AM. J. PSYCHIATRY 1061 (1980). The researchers viewed commitment papers and hospital records of patients to determine the accuracy of psychiatrists' dangerousness judgments in an emergency clinical setting. In addition, they searched hospital records for assaultive incidents noted during the 45 days following hospital admissions. Assaults were rated for severity as follows: 1+ — a serious threat that led to no action; 2+ — a threat that led to restraint because of staff anxiety; 3+ — an act that required immediate intervention to prevent a battery; and 4+ — a

ies show that psychiatrists overpredict, rather than underpredict, dangerousness.[140] In fact, one researcher has concluded that approximately sixty-five to ninety-five percent of psychiatric judgments of dangerousness to others are incorrect.[141] In addition, there is evidence that psychiatrists tend to be less accurate than psychologists and social workers in their predictions of dangerousness.[142] Thus, there is a high likelihood that psychiatrists will frequently err by finding probable cause of dangerousness to self or others when none exists.

No studies are available that have attempted to measure the accuracy of psychiatrists' judgments about the existence of grave disability. However, as the court in *Doe v. Gallinot*[143] recognized, there is a substantial risk of erroneous application of the LPS Act's grave disability standard

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completed battery. The frequency of in-hospital assaults by 59 patients committed on an emergency basis on the grounds of dangerousness to others was compared to the frequency of in-hospital assaults by 59 patients who were confined for other reasons. The researchers found that 45% of the persons confined on the grounds of dangerousness committed assaults and 13% committed a battery within 45 days after admission. Of the persons confined for other reasons, 8% committed assaults and 3% committed batteries. The researchers concluded that dangerousness was predicted to a significant degree. *Id.*

The Rofman, Askinazi and Fant study has been criticized. *See* Roth, *Dangerousness: In the Eye of the Beholder?*, 138 AM. J. PSYCHIATRY 995 (1981) (letter to the editor). Roth stated that the authors' conclusion was only supported because they included lesser acts on their scale of assaultiveness. He asserted that categories 1+ and 2+ indicated only that the patients were feared, as opposed to actually dangerous. *Id.*

Although psychiatrists tend to overpredict dangerousness, there is evidence that other mental health professionals may underpredict dangerousness to self. For a study suggesting that psychiatrists may be better in recognizing suicidal individuals than other professionals, see Holmes & Howard, *Recognition of Suicidal Lethality Factors by Physicians, Mental Health Professionals, Ministers, and College Students*, 48 J. CONSULTING & CLINICAL PSYCHOLOGY 383 (1980) (psychiatrists scored higher than other professionals on the "Lethality Scale," a multiple choice test designed to measure the recognition of suicidal traits). For a discussion explaining why the Lethality Scale may not be an accurate measurement of a person's ability to identify suicidal individuals, see Inman & Kahn, *Recognition of Suicidal Lethality Factors by Psychiatric Nursing Assistants*, 51 PSYCHOLOGICAL REP. 197, 198 (1982).

[140] Ennis & Litwack, *supra* note 116, at 711-16 and sources cited therein.

[141] *Id.* at 715, *quoting* Monahan, *The Prediction and Prevention of Violence*, in PROCEEDINGS OF THE PACIFIC NORTHWEST CONFERENCE ON VIOLENCE AND CRIMINAL JUSTICE (Issaquah, Wash., Dec. 6-8, 1973).

[142] A thorough survey of all the published literature on antisocial conduct has been conducted. Dershowitz, *supra* note 139, at 47. The author concluded that studies strongly suggest that psychiatrists are less accurate than psychologists, social workers, and correctional officers in predicting violent behavior. *Id.*

[143] 486 F. Supp. 983 (C.D. Cal. 1979), *aff'd*, 657 F.2d 1017 (9th Cir. 1981).

because of the Act's imprecise criteria,[144] which allow the interjection of personal biases and orientations.[145] Psychiatrists' biases and orientations seem likely to influence their determinations of probable cause of grave disability. Thus, psychiatrists may be prone to err on the side of finding grave disability when it does not exist, as a result of medical school training emphasizing caution,[146] their relatively low tolerance for abnormal behavior,[147] and their susceptibility to influence by peer judgments.[148]

In sum, there is substantial doubt that psychiatrists can function as neutral and detached hearing officers. This lack of impartiality could cause psychiatrists to find probable cause of a mental disorder resulting in dangerousness or grave disability when it does not exist. Thus, a substantial risk arises that persons would be erroneously confined when psychiatrists serve as certification review hearing officers. In addition, studies suggest that other persons are more likely to be impartial and valid in their judgments.[149] Eliminating psychiatrists from the list of eligible persons who may serve as hearing officers may reduce the likelihood of erroneous confinements.

3. The State's Interest in Having Psychiatrists Serve as Hearing Officers

The state has both a *parens patriae*[150] and a police power[151] interest in involuntarily confining persons. Under the state's *parens patriae* au-

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[144] *Id.* at 992. The grave disability standard has withstood challenges for vagueness because it implicitly requires a finding of dangerousness to self. *Id.* at 991; *cf. In re* Chambers, 71 Cal. App. 3d 277, 284, 139 Cal. Rptr. 357, 362 (1st Dist. 1977) (grave disability standard sufficiently precise to exclude unusual or nonconformist lifestyles). However, as the court in *Gallinot* recognized, even though the standard is not unconstitutionally vague, there is a significant risk of error in its application. *Gallinot*, 486 F. Supp. at 991.

One article, Tieger & Kresser, *supra* note 87, at 1418 n.47, provides a good example of how this standard may be erroneously applied. A patient's chart reported that she spent all day in bed as evidence of her grave disability. However, the truth was that the patient enjoyed reading, and her bed was the only place that was both comfortable and quiet enough to allow reading. *Id.*

[145] Ennis & Litwack, *supra* note 116, at 727.

[146] *See supra* note 116 and accompanying text.

[147] *See supra* note 118 and accompanying text.

[148] *See supra* note 119 and accompanying text.

[149] *See infra* notes 168-75 and accompanying text.

[150] *Parens patriae* is a Latin phrase which means "parent of the country." BLACK'S LAW DICTIONARY 1003 (rev. 5th ed. 1979). *Parens patriae* authority originates from the English common law, which gave the King authority to act as guardian for persons with legal disabilities, such as infants, idiots, and lunatics. In the United States, the *parens patriae* power belongs to the states. *Id.*

[151] Police power is the government's authority to prevent crime, and protect the com-

thority, commitments are justified on the grounds that the state is protecting persons who are incapable of caring for themselves.[152] The United States Supreme Court recognizes that *parens patriae* power authorizes civil commitments of mentally disordered persons.[153] The state's police power is the authority that allows it to prevent a person from harming others.[154] The Supreme Court has also recognized that a state may civilly confine a person to protect society from her.[155]

In exercising both its police and *parens patriae* powers, the state does not have the authority to involuntarily confine a person who is not a danger to herself or others.[156] Therefore, the state's interests are served only if persons are not erroneously confined. Considering the high risk of error in psychiatric judgments[157] and psychiatrists' overall unsuitability to serve as neutral factfinders,[158] the state's *parens patriae* and police power interests are not furthered by having psychiatrists serve as hearing officers.

The state's fiscal and administrative interests also must be considered.[159] Removing psychiatrists from the list of persons eligible to serve

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fort, safety, morals, and health of its citizens. *Id.* at 1041.

[152] *Civil Commitment*, *supra* note 86, at 1207-16. For further discussion of the history of the states' *parens patriae* power and its development in the law, see generally Livermore, Malmquist & Meehl, *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75 (1968).

[153] Addington v. Texas, 441 U.S. 418, 426 (1979); Jackson v. Indiana, 406 U.S. 715, 737 (1972). However, there are limits on the state's *parens patriae* power to involuntarily confine a person. The Supreme Court has held that a state cannot constitutionally confine a nondangerous person who is capable of surviving safely in freedom by herself or with the help of family members and friends. O'Connor v. Donaldson, 422 U.S. 563, 575-76 (1975). Mere public intolerance or animosity does not justify the involuntary confinement of a person. Moreover, a person may not be confined solely for the purpose of providing treatment. *Id.*

[154] *Civil Commitment*, *supra* note 86, at 1222-45.

[155] Jackson v. Indiana, 406 U.S. 715, 737 (1972); Humphrey v. Cady, 405 U.S. 504, 509 (1972).

[156] *Cf. In re* Roger S., 19 Cal. 3d 921, 930, 569 P.2d 1286, 1291, 141 Cal. Rptr. 298, 303 (1977) (state does not have an interest in committing a child to a state mental hospital for care and treatment if the child is not in need of treatment). In addition, the state has a "significant interest in confining the use of its costly mental health facilities to cases of genuine need." Parham v. J.R., 442 U.S. 584, 605 (1979). When a person is erroneously confined, this interest is thwarted.

[157] *See supra* notes 122-49 and accompanying text.

[158] *See supra* notes 115-49 and accompanying text.

[159] Mathews v. Eldridge, 424 U.S. 319, 335 (1976).

as hearing officers would neither impose a fiscal burden on the state nor cause additional administrative burdens.[160] In addition, deleting psychiatrists from the list of eligible individuals would not significantly affect the degree of flexibility allowed for selecting hearing officers, given the large pool of qualified persons available as certification review hearing officers.[161] The deletion would neither require a more elaborate procedure nor impose any additional administrative burdens on the state.[162] Furthermore, having psychiatrists serve as hearing officers is probably more expensive than having other eligible persons serve.[163] Therefore, deleting them from the list of eligible hearing officers seems likely to benefit rather than impose a fiscal burden on the state.

III. PROPOSAL FOR MORE EFFECTIVE CERTIFICATION REVIEW HEARING OFFICERS

A. Psychiatrists, Medical Doctors, and Nurses

Because of their inherent lack of impartiality,[164] using psychiatrists as certification review hearing officers seems unconstitutional. Not all psychiatrists are incapable of serving as neutral and detached hearing

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[160] *See infra* notes 161-63 and accompanying text.

[161] *See supra* notes 28-31 and accompanying text.

[162] The statute, CAL. WELF. & INST. CODE § 5256.1 (West Supp. 1984), states that "[c]ertification review hearing officers shall be selected from a list of eligible persons unanimously approved by a panel composed of the local mental health director, the county public defender, and the county counsel or district attorney designated by the county board of supervisors." Because selecting psychiatrists involves the same administrative procedure as the selection of other professionals as hearing officers, eliminating psychiatrists from the list of eligible hearing officers would not impose any additional administrative burdens on the state. Other hearing officers can be selected just as easily.

[163] While the LPS Act does not provide for the compensation of hearing officers, professional groups that earn more than others are likely to require a higher fee for their time. Psychiatrists generally receive a higher salary than other mental health professionals. For example, in Atascadero State Hospital the 1981-82 monthly salary ranges for professionals were the following:

(a) Staff Psychiatrist $3,921-$5,122;
(b) Physician $3,566-$5,122;
(c) Psychologist $2,278-$2,748;
(d) Psychiatric Social Worker $1,724-$2,073; and
(e) Registered Nurse II $1,609-$2,124.

State of California Salaries and Wages Supplement for 1983-84, Health and Welfare at 85-86 (submitted by Governor George Deukmejian to the California Legislature 1983-84 Regular Session).

[164] *See supra* text accompanying notes 115-49.

officers, but psychiatrists generally are not well suited for this function. Procedural due process rules are shaped by the general risk of error, not the risk of error in rare situations.[165] Therefore, this Comment proposes that the California Legislature amend section 5256.1 of the Welfare and Institutions Code to exclude psychiatrists from the list of eligible hearing officers. In addition to complying with constitutional guarantees, eliminating psychiatrists from the list of eligible certification review hearing officers would help further the LPS Act's objective of ending inappropriate commitments.[166]

Research has not revealed any studies which have compared the biases and mental health judgment validity rates of either nurses or nonpsychiatrist medical doctors. Thus, there is no scientific evidence indicating whether or not they would make more effective hearing officers than psychiatrists. However, because of the similarities of the training and beliefs of these three professional groups,[167] study results of psychiatrists may be generalized to both nurses and nonpsychiatrist medical doctors. Therefore, this Comment suggests that medical doctors and nurses likewise be deleted from the list of eligible certification review hearing officers.

B. Social Workers and Psychologists

As discussed previously, studies of psychiatrists should not be generalized to either psychologists or social workers because these two professional groups do not share the attitudes and beliefs of the psychiatric profession.[168] Additionally, there is evidence that both psychologists and social workers are likely to be more effective hearing officers than psychiatrists.[169]

One study showed that psychologists are less likely than psychiatrists to attribute the patient's behavioral problems to her personal disposition.[170] In addition, there is a positive relationship between attribution of personal dispositions as the cause of behavior problems and referring

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[165] Mathews v. Eldridge, 424 U.S. 319, 344 (1976).

[166] *See supra* note 9.

[167] *See supra* notes 101-11, 114 and accompanying text.

[168] *See supra* notes 101-13 and accompanying text.

[169] *See infra* notes 170-75 and accompanying text.

[170] In one study, psychiatrists, psychologists, and a control group appraised cases of persons with problem behaviors. When asked to give a judgment on the likely causes of the behavioral problems, psychiatrists gave significantly more personal attributions than did psychologists and control subjects. Antonio & Innes, *Attribution Biases of Psychiatrists and Psychologists*, 43 PSYCHOLOGICAL REP. 1149 (1978).

a patient to a mental hospital. Psychologists are more likely to suggest changes in social circumstances and the use of welfare services than hospitalization.[171] This difference in orientation seems to make psychologists more suitable than psychiatrists as certification review hearing officers especially when hearing cases involving persons allegedly "gravely disabled." Psychologists are more apt to appreciate support services short of hospitalization[172] that could help a person provide for food, clothing, and shelter needs.

Another study showed that psychologists are less susceptible to being influenced by suggestions of mental illness made by other mental health professionals than are psychiatrists.[173] This difference makes psychologists more suitable than psychiatrists as certification review hearing officers. A certification review hearing officer must independently review mental health professionals' determinations that the criteria for fourteen days of involuntary confinement are met.[174] Since they are less influenced by prior determinations of mental illness, psychologists are more capable of making neutral and detached evaluations of patients' conditions.

There is evidence that both psychologists and social workers are more accurate predictors of violent behavior than psychiatrists.[175] Therefore, there is a likelihood that psychologists and social workers will err less than psychiatrists in making determinations about probable cause of dangerousness.

This Comment proposes that both psychologists and social workers continue to be eligible certification review hearing officers because their orientations toward mental health make them suitable for this role.

CONCLUSION

California legislation allowing mental health professionals to serve as certification review hearing officers raises questions as to the ability of these professionals to serve as impartial decisionmakers. Studies have

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[171] *Id.* at 1149.

[172] Antonio and Innes concluded that the results of their study suggest that "psychiatrists would recommend physical treatment of disorders and referral to hospitals but the psychologists would suggest changes in social circumstances and use of welfare services." *Id.* at 1149.

[173] *See supra* note 119.

[174] *See supra* note 121.

[175] *See supra* note 142. There is also evidence suggesting that lawyers, law students, undergraduate students, graduate students, and correctional officers would make more suitable hearing officers than psychiatrists. *See supra* notes 118, 119, 142.

tended to concentrate on examining the biases of psychiatrists and the validity of their commitment judgments. The results of these empirical studies, coupled with the personal liberty interests at stake in civil commitments, have cast doubt upon the constitutionality of psychiatrists serving as hearing officers. This Comment proposes their elimination as hearing officers.

This Comment further examines the validity of generalizing the empirical study results of psychiatrists to other mental health professional groups. It is suggested that study results of psychiatrists may be generalized to medical doctors and nurses, whose attitudes and orientations are similar to those of psychiatrists. As a result, they should be removed from the list of eligible hearing officers as well. Since social workers and psychologists have different attitudes and beliefs than psychiatrists, study results of psychiatrists should not be generalized to them. Psychologists and social workers should continue to serve as certification review hearing officers.

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