



Probable Cause Hearing Techniques

In the past two Advocacy Tools we have provided you with information about the hearing process, the required legal standards and the many details of subpoenas, legal brief, developing evidence that supports your client's position, and finally what to expect in the hearing. Understanding the legal standards is an important start to effective hearing representation.

In Certification Review Hearings you must filter fact from opinion and present a large amount of information in a short amount of time. You have a very short time to prepare and sometimes the very informality of the hearings makes it difficult to prepare. Advocates have been assisting clients in these hearings for a long time; there is a large body of experience and tools that have been developed over the years. Included in this chapter are some basic hearing techniques as well as advocacy tools that advocates have been developing over the years.

This chapter will share some of the techniques and tools that may assist you and your clients' in hearing preparation and presentation.



Chapter 1 – Legal Standards – Probable Cause Hearings
Chapter 2 – Legal Standards – Administrative/Fair Hearings
Chapter 3 – Hearing Techniques – Probable Cause Hearings
Chapter 4 – Hearing Techniques – Administrative/Fair Hearings

Table of Contents

✦ Chart Review

- Overview of What to Look For 4
 - ✕ Procedural Issues 5
 - ✕ Clinical Issues 5
- Criteria 6
 - ✕ Danger to Self 7
 - ✕ Danger to Others 7
 - ✕ Grave Disability 7
- Verifying Third Party Assistance 8
- Cultural Interpretation 8-9

✦ CLIENT INTERVIEW

- Interview Techniques 10

✦ HEARING TECHNIQUES

- Procedural Arguments 11
- Opening Statements 11
- Perfecting Your Questions 12
- Witnesses and Other Evidence 13
 - ✕ Relevance 13
- Closing Statement 13
- Hearing Tips 14-16
- Conclusion of the Hearing 16
 - ✕ Writ of Habeas Corpus 16

✈ ATTACHMENTS

A	Medical Terminology	17-18
A	Common Prefixes and Suffixes	19
B	Certification Review Prep Forms	20-21
C	Certification Review/Probable Cause Checklist	22-27
D	Hearing Officer Checklist	28-29
E	Interpreting Laboratory Reports	30

Reference Materials Utilized

Welfare & Institutions Code

Probable Cause Hearing Manual-(PAI October 1990)

Patients' Rights Advocate Manual-(DMH Contract # 95-75105)

California Judges Benchguide – Produced by California Center for Judicial Education & Research, LPS Proceedings.

Attachment B – Provided by Mental Health Consumer Concerns

OVERVIEW OF WHAT TO LOOK FOR

1- What the records fail to say that they are supposed to say.

Many times, **what the record does not say is important.** For example, the facility representative has stated on the certification review form (5250) that one of the reasons the patient is considered as gravely disabled is because she is not eating. However, your review of the progress notes does not reveal whether the patient is eating or not, and the patient reports eating at each meal. If the facility representative includes the patients' lack of eating in the hearing as evidence of grave disability, you may challenge this statement by pointing out that the record does not indicate the patients eating habits.

Record reviews are an excellent opportunity to see how well a facility understands and follows required procedures.

The Basics to Look For Include:

- Discrepancies in information,
- Advisement and certification documentation discrepancies,
- Information that supports the client.

One of the most important principles in chart reviews is to follow-up on unusual comments or notations. Read all progress notes carefully. Follow the thread of an event or issue throughout the record, i.e. if there is a doctor's order for the patient to be given an antacid, go back to the Progress Notes and see why the doctor has prescribed this medication. (Was the patient experiencing nausea possibly from the new medication she is taking). This may be why she has had difficulty with eating in the morning.

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Empowerment Resource #03 on Medical Records has a number of useful tools – If you do not have it in your resource files, you can download it from the OPR website – www.pai-ca.org/opr

Procedural Issues

Before you look for information about your client's condition and situation, you need to look at the legal documents in the chart to ensure that all legal requirements have been completed properly. If they have not, you need to raise the problems with the hearing officer.

- 5150-72 hour evaluation form check list:
 - ♦ Has it been signed?
 - ♦ Does it indicate advisement was given or the reason why it wasn't?

- 5250-14 day certification form (and 5270-30 day cert. if applicable):
 - ♦ Has the client received the notice of certification form?
 - ♦ Is the statement in the lower portion of the certification form advising the client of due process rights signed?
 - ♦ Was it signed by two authorized persons?
 - ♦ Do the dates of the signatures on the 14-day certification coincide with the date of initiation?
 - ♦ Look for pre-signed or post-signed certification documents.

- 5150 & 5250:
 - ♦ Have the legal time constraints for the detention been exceeded? Remember: Clients must be credited with time for all voluntary intervals of treatment during the 72-hours and 14 day certification period.
 - ♦ Are the criteria for both documents the same? They do not have to be but the same however, changes in criteria may be cause for a closer look and/or comment.
 - ♦ Is the "Involuntary Patient Advisory" form in the chart and signed?

Clinical Issues

Look for very specific information in the medical record. It is especially important to pay attention to documentation of the circumstances that led to the client's hospitalization and to the client's condition when they arrived (see chart review).

Notation(s) about the following may require additional information;

- Indications that the client was placed in seclusion or restraint, or any other negative incidents. If it is safe to do so, ask your client if they would like to discuss the incident and explain that it may be further

discussed in the hearing. Try to prepare an explanation for your client's behavior that is based on their perception of the precipitating events.

Look for the following notations or signs of patient improvement:

- Cooperation/calmness upon admission to the unit,
- Positive descriptions of the client's condition or behavior,
- Possible signs of improvement, discontinuation of 1:1, eating or sleeping, participation in unit activities,
- Decreased or discontinued medication,
- Charting that problematic behaviors have ceased or decreased.
- Positive physical health reports, particularly as it applies to grave disability. Review any lab tests; they are an important way to attest to the client's current physical condition. It may be important to present to the hearing officer the fact that the seemingly unconventional way that the client has provided for food, clothing and shelter has not necessarily adversely affected their health.
- Documentation that the client is eating and sleeping well.
- Voluntary consent forms signed by the client. If this is present, the staff must have decided the client is able and willing to accept treatment. The law; Welfare & Institutions Code §5250 (c), states that the client be advised of voluntary treatment prior to placement on an involuntary hold. It is the facilities responsibility to show that the client's condition has changed to preclude voluntary treatment.

CRITERIA / GROUNDS FOR CERTIFICATION

If a person is detained for 72 hours or committed by a court order for evaluation and has received an evaluation, he or she may be certified for not more than 14 days of intensive treatment related to the mental disorder or impairment by chronic alcoholism. The person must be found to present a danger to others or a

danger to self, or gravely disabled, as a result of the mental disorder or impairment by chronic alcoholism.

When reviewing the chart it is important to follow the thread of why the person was initially placed in the hospital involuntarily. Look for whether or not the documentation meets the criteria. It is important in the hearing that only the information that is relevant to the criteria is presented i.e. if the patient was certified as a danger to others and not on grave disability, it is not relevant whether they have been showering or not.

The following is a broader discussion of the three criteria.

Danger to Self

The statute does not define the term "Danger to Self. In practice, the following is often used to determine "Danger to Self".

A deliberate intention to injure oneself or a disregard for personal safety to the point where injury is imminent. The danger must be present, immediate, substantial, physical, and demonstrable.

Danger to Others

The statute does not define the term "Danger to Others". In practice, the following is often used to determine "Danger to Others".

Words or actions that indicate the person in question has indicated the intent and ability to cause harm to a particular individual or intends to engage in dangerous acts with gross disregard for the safety of others.

If your client has been in restraints and/or seclusion you need to know what happened and why it happened. Determine if there is a way to explain the behavior favorably for your client.

Grave Disability

Welfare & Institutions Code §5008(h) defines "Gravely Disabled" as a condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing or shelter.

The mere inability to provide for basic personal needs is not sufficient grounds. Nor is refusal of treatment evidence of grave disability. If there are family

members, friends, or a third party who are willing to help with the provisions of food, clothing, and shelter then the criteria for gravely disabled is not met.

Look for participation in treatment and unit activities, whether he/she is eating, showering, sleeping. Review any lab tests that were taken, if they are all within normal range it is a strong indication that your client is taking sufficient care of him/her self. Also note, regardless of the person's past, the question is whether they are presently gravely disabled.

VERIFYING THIRD PARTY ASSISTANCE

The statute requires anyone willing to provide 3rd party assistance to indicate this in writing, if they cannot come to the hearing in person. Because of the time constraints of most hearing schedule, some counties have created a protocol that allows the advocate to verify that the friend or family agrees to assist the client via a tape recorder. It is important to gain consent of the person you intend to tape record prior to recording the conversation. You will need to explain that you intend to use a taping device and that you plan on using the recorded information at the hearing. Make certain that everyone (hearing officer, mental health director, hospital administration and advocate) agrees with the "script" that the advocate will read to the person and that they affirm that they are agreeing to provide assistance. The tape is then used at the hearing.

CULTURAL INTERPRETATION

It is important to look at cultural interpretations of a behavior that may be documented in such a manner that there is cause for confusion. What may appear to be evidence of grave disability to one culture may not be to a person of another culture and may be misunderstood because of lack of diverse cultural knowledge.

For example:

- A person who sleeps on the floor instead of the bed may do so because it is culturally acceptable.
- A person who refuses to eat until sundown. (many religions have fasting or spiritual observances that would include this practice)
- Someone who is heard Chanting continuously by be misunderstood by those who do not practice Chanting or ritual prayers.

There must be a willingness to understand cultural differences in order to effectively and responsibly serve the community as a whole. It is important to identify those actions or lack of actions of the client that the facility may be presenting as a symptom of mental illness when it that demonstrates their (the facilities) lack of cultural awareness.

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If no probable cause is found, and the patient chooses to leave the hospital, they must be provided with proper discharge plans. The facility should have begun the process when the patient first came into the hospital. Under no circumstances may a patient be sent away from the hospital without medications and a way to get home. Federal regulations require these be provided. (See Empowerment Resource # 12 – Discharge Planning)

Some advocates interview the client first before reading the medical record; others review first and interview after. No matter what your preference, the interview is important. This is the first time you get information directly from your client and it is your chance to clarify and/or understand why your client is in the hospital and what their wishes are. You can help them understand the involuntary hold process and what their options are. It is important to remember your role is to assist the client in presenting their “expressed interest,” others are focused on the “best interest” of the client. Your role is very important.

INTERVIEW TECHNIQUES

- First, Introduce yourself and your role,
- Inform the client that you do not work for the hospital,
- Establish how they wish to be addressed. Do not assume familiarity by using first names unless they give you permission,
- Find a Safe and private interview space,
- Explain the hearing process. Tell the client what to expect, where the hearing may be held, who will be there,
- Tell the client if there is information they do not want presented at the hearing they should let you know,
- When you are trying to establish rapport, be aware of the client's needs and preferences. Be aware of cultural implications.
- Be aware of cultural implications,
- Advise your client about the importance of demeanor and appearance at the hearing and obtain any help they may require to prepare, i.e. request staff to facilitate shaving, showers, clean clothing, etc.

Information to look for:

- Listen to the client's explanation of why they are in the hospital,
- Ask if they have a plan after being discharged from the hospital, i.e. a place to live or plans to attend outpatient treatment,
- Find out what has changed that was present when they were initially hospitalized.
- Ask if they are they willing to stay in the hospital voluntarily?

Taking Notes can be an important tool to:

- Maintain a record of the interview,
- Assist with recalling interview,
- Assist in prevention of misinterpretations of statements,
- Notes of exact word or phrases used,
- Listen then write.

Many programs have developed a form that is used to gather information. (See attachment C)

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If your client feels unprepared to attend the hearing, (e.g. someone who the client wishes to attend cannot be reached) or you cannot establish the client's wishes (e.g. the client refuses to speak to you) you can postpone the hearing for 48 hours or in counties of 100,000 or less to the next hearing day. Always, clear this decision with your client and the hearing officer.

✈ HEARING TECHNIQUES

PROCEDURAL ARGUMENTS

Procedural issues in a certification review hearing may include:

- Lack of signatures,
- Timing problems,
- Evidence the client was not advised of the hearing or the ability to stay on a voluntary basis.

Normally, hearing officers prefer to hear argument on any procedural issue prior to presentation of substantive evidence. You may even want to bring it up before the hearing begins.

If the hearing officer will not consider procedural defects in the certification petition, the advocate should still point out procedural problems and the correct procedure to avoid problems in the future.

OPENING STATEMENT

Present your client's position. Establish your opinion that the facility has not met the burden of proof to continue to hold your client involuntarily. You are setting the stage for the questions you will be asking the facility representative, the client and any other witnesses.

If voluntary treatment has not been offered to your client (and they are willing to stay for treatment) this is a good time to raise the issue. This may be the only time until you make your closing statement that you will be able to provide information that is not in the form of a question. Make sure any information you provide is documented or supported.

PERFECTING YOUR QUESTIONS

Keep the following in mind when you are soliciting testimony from the facility representative:

- Avoid asking “why” questions unless you have a good sense that the answer will be,
- Ask questions designed to elicit favorable responses first,
- Ask questions that challenge unfavorable testimony last,
- Break down questions into separate components, addressing one fact at a time,
- Revise your questions as appropriate and follow up on leads.

Keep the following in mind when soliciting testimony from the client:

- Draft a detailed list of questions based on your interview with the client and your review of the medical record;
- If the client’s testimony is likely to appear to be illogical or disorganized, keep the testimony very brief and focused;
- Ask the client in advance all of the questions that you intend to ask at the hearing. Try to avoid the appearance of coaching the client.

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Anticipate the problems and plan for them. What is going to come up that could cause problems with your argument. What issues may come up with your client and or witnesses.

If your client has received medication in the last 24 hours the hearing officer must be informed of this. It is the hospital’s responsibility to provide this information, but make sure you raise it if they do not. Also use the mediation information in the Empowerment Resource (#03) and other resources to provide information about the side effects of a specific medication. (This may be why they are having difficulty paying attention or speaking clearly)

WITNESSES AND OTHER EVIDENCE

Try to anticipate what a witness will say before you ask them to testify in the hearing. Family, friends and clinical staff may have important evidence.

If an outside witness (such as a staff member, family or friend) with good evidence refuses or is unable to testify, you may be allowed to summarize the evidence for the hearing officer. If you have documented evidence (e.g., a description of side effects from a medication text, a letter from the client, friend or family; an informed consent from a provider) to present, be prepared to explain why you think it is important to present.

Remember that clinical staff may present conflicting or unfavorable testimony.

Relevance

All evidence presented by both sides should be relevant to the question of whether or not the person being held meets the commitment criteria as indicated on the 14-day certification.

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Consider giving your client paper and pencil to write down any information or questions during the hearing that they wish to respond to or ask. This will avoid interruptions during the hearing process.

CLOSING STATEMENT

State your arguments and summarize the evidence which supports each argument. The closing statement should:

- 1) Identify each issue addressed,
- 2) The legal standards needed for continued hold,
- 3) The evidence in support of your client's release.

HEARING TIPS

× Address willingness and ability to be voluntary

If the hearing officers will not rule on voluntary status, the advocate should highlight facts demonstrating the clients' willingness and ability to receive treatment on a voluntary basis. Emphasize that willingness and ability to be voluntary is a threshold issue in the certification. Willingness and ability to be voluntary can also be used to indicate that the client is not dangerous or gravely disabled.

× Push for removal of "danger to self and/or others "

Often, you will find that all criteria are checked on the 5150 and 5250. Eliminating a danger to self and/or others from a certification form not only reduces the number of elements to be challenged in later proceedings, but reduces the stigma and negative implications of a finding of dangerousness when it does not exist. If specific information is not provided to support criteria for danger to self or others, then request the removal of the finding from the certification. This can be done at the beginning of the 5250 certification hearing.

× Challenge the facts presented

Listen carefully to the facts presented. Challenge misstatements, inference and speculation. Point out errors and omissions in factual presentations. Be sure you emphasize the clients' strength and abilities. When opinion or theories are presented by the facility identify them and contrast them with facts.

× Using the hearing process to educate

A part of all hearing preparation should be informing the client of the commitment process and how to successfully challenge it should they desire to do so. It may also be a good time to encourage a client to ask questions and make requests for assistance on other problem they may be experiencing while hospitalized (i.e. requesting a room change may help them sleep better). In addition, try to use the hearing process to inform staff about the current laws and regulations as applicable.

× Get to know how the hearing officer makes decisions

Learn what your hearing officer is looking for – what information do they consider the most when deciding whether to release clients. For example, it may be

important for the hearing officer to know that the client will continue outpatient treatment. You may want to ask the hearing officer (outside the hearing) what information they would like presented. Review your hearings – debrief with other advocates if possible to help you understand the hearing officer's decision making process.

× **Watch other advocates provide hearing representation**

Observing other advocates can be one of the most effective ways to develop your own advocacy skills and ideas for new and creative arguments. Watch the proceeding carefully, analyzing strategy, language and presentation.

× **Develop your skills through seminars and instructional materials**

Take a course in debate/argument. Read a book on persuasion, public speaking, negotiations. Try out what you've learned in the hearing.

Advocacy Guide –

Recent changes to the W & I § 5008 – Added to (a) - [The historical course shall include, but is not limited to, evidence presented by persons who have provided, or are providing, mental health or related support services to the patient, the patient's medical records as presented to the court, including psychiatric records, or evidence voluntarily presented by family members, the patient, or any other person designated by the patient. **Facilities shall make every reasonable effort to make information provided by the patient's family available to the court.** The hearing officer, court, or jury shall exclude from consideration evidence it determines to be irrelevant because of remoteness of time or dissimilarity of circumstances.

Added (b) this section shall not be applied to limit the application of Section 5328 or to limit existing rights of a patient to respond to evidence presented to the court.

What this means: If the family has information they would like the hearing officer to have, they can give it to the facility representative to present. The hearing officer can decide if he/she feels it is relevant. If you have information that contradicts the information the family provides, make sure you present it to the hearing officer. The patient continues to decide whether the family can attend the hearing or not, W&I § 5256.4(c) – provides that the family is only notified of the hearing if the client wants them notified.

× **Stay in close communication with your client**

Sit near or beside your client. This establishes that you are there to assist/support them. This also allows for privacy if you need to clarify something or dissuade your client from interrupting etc.

× **Question the “Facts”**

Don't accept information at face value. Whether it is in the record or presented at the hearing. Just because it is written down doesn't make it true. Information can be recorded incorrectly and then it continues to be repeated over and over without verification of where the information came from. Although hearsay information is allowed, it doesn't hurt to point out that it is hearsay. Question the source. It is easy for information to get distorted or misunderstood.

× **Explore the reason for your client's behavior**

Is the behavior in fact due to a mental disorder or simply due to poverty, an alternative life style, an antisocial personality, drugs, alcohol, etc?

CONCLUSION OF THE HEARING

It maybe your responsibility to explain the decision to the client if the hearing officer does not. If probable cause was found, you or the hearing officer should explain the clients' right to appeal the decision by filing a writ of habeas corpus. Follow whatever process your county has agreed on. Also, don't forget to advise the client that they can request a writ at any time during the involuntary hold by calling their Patients' Rights Advocate or telling staff.

WRIT OF HABEAS CORPUS

The role of the advocate in the filing of writs differs from county to county. However, all advocates have the responsibility to make sure that the patient has been advised of their right to request a writ.

One thing to consider, if you feel the client had compelling information that either comes to light after the Probable Cause hearing or that the hearing officer did not consider relevant and you disagree, you should provide the information you have obtained to the public defender who will be representing your client at Writ (with the clients' permission).

Attachment A

MEDICAL TERMINOLOGY & ABBREVIATIONS:

Abrev:	Meaning:
Aa	of each
Abd	abdomen
Ac	before meals
ad	right ear
ad lib	as needed
AK	above knee
A.M.	morning
amb.	ambulatory, walking
amt.	amount
approx.	approximately (about)
AS	left ear or aortic stenosis
AU	both ears
A & W	alive and well
ax	axillary (armpit)
b.i.d.	twice per day
BK	below knee
bilat.	Bilateral
BM	bowel movement
BP	blood pressure
BRP	bathroom privileges
BS	bowel sounds
C	Centigrade
c	with
cc	cubic centimeter
CC	chief complaint
cmpd	compound
CNS	Central Nervous System
CONTRA	contraindication
c/o	complaints, complains of
d	died
DC	discontinue
D/C	discharge
D & C	dilation and curettage
DSG	dressing
DX	diagnosis

ECG (EKG)	electrocardiogram (tracing of heart function)
EEG	electroencephalogram (brain wave tracing)
ER	emergency room
e.g.	for example
esp.	especially
ETIOL	etiology
EBL	estimated blood loss
exam.	Examination
ex	example
ext	extract or extremities
F	Fahrenheit
FF	force fluids
FH	family history
fld	fluid
ft	foot
FUNCT	function
FUO	fever of unknown origin
GI	gastrointestinal (stomach and intestines)
gm	gram (measurement)
gr	grain (measurement)
gtt	drop (measurement)
GU	genitourinary (pertaining to organs of reproduction and urinary excretion)
h	hour
H & P	history and physical
HR	heart rate
HS	bedtime
i.e.	that is
irrig.	irrigate
IM	intramuscular
IMP	impression
incont.	incontinent

I & O	intake and output
IV	intravenous (within vein)
kg	kilogram (weight)
lb	pound
liq.	liquid
LLQ	left lower quadrant (left lower section of abdomen)
LMP	last menstrual period
LUQ	left upper quadrant (left upper section of abdomen)
med.	medical or medication, medicated
mid	middle
min.	minute
mg.	milligram (measurement)
ml.	milliliter (measurement)
mm.	millimeter (measurement)
no.	number
noc.	night
NPO	nothing by mouth
NSFTVD	normal, spontaneous, full term vaginal delivery
Abbreviations:	Meaning:
N & V	nausea and vomiting
o.d.	right eye
OD	overdose
o.s.	left eye
o.u.	each eye, both eyes
oz.	ounce
P	pulse
PC	after meals
PE	physical exam
per	by or through
PERRLA	pupils equal, round, react to light, accommodate
pert.	pertaining
PI	present illness

po	by mouth
post op	post operative (after surgery)
prn	when necessary
pre op	pre-operative (before surgery)
prog.	prognosis
psych	psychology, psychologist
pt.	patient
PTA	prior to admission
qd	every day
qh	every hour
qid	4 x per day
qod	every other day
q.s.	quantity sufficient
R or resp	respirations
rel	related, relating
RLQ	right lower quadrant (right lower quarter of abdomen)
RUQ	right upper quadrant (right upper quarter of abdomen)
SH	social history
SOB	shortness of breath
sol	solution
stat	at once
tab	tablet
TPR	temperature, pulse, respiration
via	by way of
VS	vital signs (TPR)
WNL	within normal limits
WNWD	well nourished, well developed
wt	weight
yo, y/o	year old

COMMON PREFIXES AND SUFFIXES USED

Prefixes:	Meaning:	Prefixes:	Meaning:
a-, an-	not or without	hypo-	deficiency
ab-	away from	inter-	between
ad-	toward	intra-	within
adeno-	gland	kines-	movement
ambi-	both	leuko-	white
ante-	before	mal-	bad
bi-	double	mega-	large
brady-	slow	melano-	black
cardio-	heart	micro-	small
cephal-	head	myo-	muscle
circum-	around	neo-	new
contra-	against	nephro-	kidney
dent-	teeth	ped-	foot
derma-	skin	per-	through
dis-	apart	peri-	around
dorso-	back	phlebo-	vein
dys-	difficult	photo-	light
en-	within	post-	after
ex-	outside	pre-	before
eryth-	red	pseudo-	false
ferro-	iron	pyo-	pus
gastro-	stomach	pyro-	fever
glyco-	sugar	reno-	kidney
hemi-	half	steno-	narrow
hepato-	liver	sub-	under
hydro-	water	tachy-	fast
hyper-	excess	trans-	across
-algia	pain	-megaly	enlargement
-ase	enzyme	-oma	tumor
-cele	tumor/swelling	-ostomy	opening
-ectomy	surgical removal	-penia	lack of
-emesis	vomit	-phobia	fear
-emia	blood	-phylaxis	prevention
-esthesia	sensation	-plasty	repair
-itis	inflammation	-rhea	flow
-lith	stone	-scopy	examine visually
-lysis	destroy	-uria	urine

Attachment B

MENTAL HEALTH CONSUMER CONCERNS, INC.
PATIENTS' RIGHTS ADVOCACY & TRAINING- SELF-HELP PROGRAMS
716 Alhambra Avenue, Martinez, CA 94533
Tel: Solano 510-646-5788 Napa 707-253-4735

Cert. Hearing Prep Advocate _____ Interview Date (s) _____ Eth _____ Sex ____
Name _____ Age (C/A/E) _____ Hosp/Unit _____/
Address _____ County Res. _____ 5150.
Admit Date _____ Cert Date _____ Dr. _____ D.O. ____ D.S. ____ G.D. _
5250 explained ____ Vol? ____ Chart consent given ____ Chart reviewed ____ Postpone ____ Will
Attend _
Hearing Date _____ HO ____ HR ____ Results _____ Writ/Appeal _____ Ok call family/friends _____
Contact person _____ Relationship _____ Ph _____
Contact person _____ Relationship _____ Ph _____
Medication (s) _____

If client is a minor, could/will parent sign him/her in as voluntary? _____

Expressed interest _____

D.O. _____

D.S. _____

G.D. _____

Other Notes _____

PLAN OF ACTION
Client Interview Questions

- 1) What is your source of income?

- 2) Where will you live?

- 3) How or where will you eat?

- 4) How or where will you obtain your clothing?

- 5) Do you have any friends, family, church, clubs or organizations who will help you?

- 6) Do you have any support groups that you will be attending?

- 7) Do you plan to continue participating in Mental Health out-patient services?

- 8) How will you provide your transportation?

Attachment C

Certification Review/Probable Cause Hearing Checklist

Certification Review/Probable Cause Hearing Checklist

I. Initial Contact with Client

- 1. Did advocate introduce him/herself to the client?
- 2. Did advocate ask the client if s/he wished to be called by first name or Mr., Mr., etc.?
- 3. Did advocate attempt to find a private place in which to meet with the client?
- 4. Did advocate make sure that the client understood that advocates are not affiliated with the mental health facility in any way?
- 5. Did advocate assure client that any information s/he gave would held in confidence and would not be shared with anyone outside the hearing unless it was with the client's permission?
- 6. Did advocate adequately explain his/her reason for meeting with the client?
- 7. Did advocate ask client to sign a release of information form or get verbal permission before talking with anyone regarding his/her case or reviewing his/her chart?

II. Hearing Preparation

- 1. Did advocate explain the hearing procedure including time, place, participants and what the client would be likely to encounter?
- 2. Did advocate inform the client that the hearing would be informal and that the hearing was being held solely for their own protection and that the burden of proof was on the facility to show that the commitment was justified?
- 3. Did advocate explain
 - a. The reason doctor was holding client as shown on the 5250 form?
 - b. The technical grounds on which client was being held?
 - c. The ways client could overcome these grounds?

- 4. In a neutral way, did advocate ask client whether or not s/he wanted leave the hospital or stay in the hospital?
- 5. If the client wanted to stay or was unsure about leaving, did advocate explore with the client, taking the client's lead, the possibility of:
 - a. Postponing the hearing?
 - b. Requesting voluntary status?
- 6. If the client expressed the desire to leave the hospital did advocate
 - a. Ask client how hospitalization came about?
 - b. Ask for written permission to read the client's chart?
 - c. Ask permission to phone family members etc. for support and information?
- 7. Did advocate advise client that s/he did not have to answer any questions that would make him/her uncomfortable either in the interview or at the hearing and that s/he did not have to attend the hearing if s/he didn't want to?
- 8. If client did not want to attend the hearing, did advocate inform client that the hearing officer might interpret his/her participation in an unfavorable light?
- 9. Did advocate inform client that s/he could waive the hearing and proceed directly to court by petitioning for a writ of habeas corpus but that waiving the hearing would not be strategically a wise choice since, by so doing so, s/he would be losing one of his/her due process protections?
- 10. Did advocate advise client that, although things might be said at the hearing with which s/he might disagree, during the hearing it would be important not to interrupt while others were talking?
- 11. Did advocate advise client about the importance of his/her demeanor and physical appearance at the hearing?
- 12. With regard to above, did advocate offer to provide or obtain any assistance the client requested in preparing him/herself for the hearing?
- 13. Without leading the client to a particular decision, did advocate ascertain client's wishes with respect to continued hospitalization?
- 14. Did advocate ask client if s/he would like to contact anyone to verify living arrangements?
- 15. If yes to above, did advocate identify him/herself as a patients' rights advocate and clearly convey to the family member that s/her is not connected with the hospital in an way?

- ___ 16. Did advocate clearly convey to the family member that if the client were released at the hearing that it would be against medical advice but that the hearing officer would be making a decision as to whether or not, with their assistance, the client could meet his/her basic needs for food, clothing and shelter?
- ___ 17. If the hearing was postponed, was it postponed based on the expressed wishes of the client?
- ___ 18. Did advocate leave a number with the client where s/he could be reached in case the client had any questions or problems?

III. Reviewing the Chart

- 1. Did advocate look for any statements in the chart that indicate
 - ___ a. that the client was calm or cooperative in admission?
 - ___ b. that the client's condition had improved?
 - ___ c. positive descriptions of client's condition or behavior?
 - ___ d. that medication had been decreased or discontinued?
 - ___ e. positive physical health reports?
 - ___ f. existence of financial and family support?
 - ___ g. that client was placed in seclusion or restraint?
 - ___ h. that the client had been eating/sleeping well?
 - ___ i. voluntary consent forms?
- 2. Did advocate check to see if
 - ___ a. the client had been given a copy of the 14-day cert.?
 - ___ b. the 14-day cert. had been signed by two authorized persons?
 - ___ c. the 72 hr. evaluation form was in the chart and signed?
 - ___ d. the upper portion of the 72-hr. evaluation form was complete indication that proper advisement had been given to the client?
 - ___ e. the legal time constraints regarding detention had been exceeded?
 - ___ f. the narratives on the 72 hr. hold and 14-day certification substantiated each of the commitment criteria indicate?
 - ___ g. the involuntary patient advisement form had been completed and was present in the chart?
 - ___ h. the date of signatures on the 14 day cert. coincided with the date of its initiation?
- 3. Did advocate note
 - ___ a. what supported the doctor's position?
 - ___ b. what supported the client's position?

- ___ c. names and phone numbers where applicable of those who were familiar with the client?
- ___ 4. Did advocate speak to individuals who knew of the incident which resulted in the client being brought to the hospital?
- ___ 5. Before calling the above individuals did advocate talk with client to determine his/her level of understanding about the incident which brought the client to the hospital?
- ___ 6. In talking with these individuals did advocate explain the role of the advocate, and the right to use hearsay evidence at the hearing, etc.?
- ___ 7. Did advocate involve client by asking him/her to give a verbal okay for release of information?

IV. Preparing the Client for the Hearing

- ___ 1. Did advocate convey to the client the reasons for the 72-hr. and 14-day certification?
- ___ 2. Did advocate get the client's side of the story?
- ___ 3. Did advocate take written notes highlighting material which would be used at the hearing?
- ___ 4. Did advocate advise the client that s/he might be asked some of the same questions at the hearing not because the advocate didn't understand or wasn't listening but so that the hearing officer could hear the answer, too?
- 5. Did advocate adequately describe the hearing process to the client by explaining
 - ___ a. where it would take place?
 - ___ b. when it would take place?
 - ___ c. who would be present at the hearing?
 - ___ d. the hearing process?
- 6. Did advocate clearly explain to the client
 - ___ a. the position of the doctor?
 - ___ b. the evidence that would support the doctor's position?
- ___ 7. Did advocate adequately explore with client the possibility of having supporters attend the hearing?
- ___ 8. Did advocate prepare the client for the hearing by asking him/her questions that the hearing officer might ask?

___ 9. Did advocate give client a pep talk before the hearing?

V. The Actual Hearing

___ 1. Did advocate cover all points that would enhance the client's case?

___ 2. If the client received medication during the 24 hrs. prior to the hearing, did advocate inform hearing officer of the medication and its side effects?

___ 3. Did advocate advise client that although s/he might elect to have family members or friends in attendance at the hearing that their statements might not support the client's own position?

___ 4. If probable cause was found, did advocate advise client of his/her right to file a request for release and to have a hearing on the request before the superior court?

___ 5. Did advocate explain the judicial procedure to the client including the fact that a public defender would be appointed if the client could not afford legal counsel and that the hearing would be held within two judicial days of the petition's filing date?

___ 6. Did advocate avoid asking client questions s/he hadn't already been asked prior to the hearing?

___ 7. Did advocate avoid eliciting information that might have cast the client in a bad light?

___ 8. If client exhibited behavior that might have been a side effect of his/her medication, did advocate point out to the hearing officer that the medication, not a mental disorder, might be responsible for the behavior?

___ 9. Did advocate attempt to sit beside the client during the hearing so as to ensure good communication with the client?

___ 10. Did advocate provide pen and paper for the client to take notes during the hearing?

___ 11. Did advocate question the presenters about the source of statements in an attempt to show that, for example, what was being presented as absolute fact might be in reality hearsay several times removed?

___ 12. Did advocate properly present the client's point of view?

___ 13. In order to help provide structure to the client's case, did advocate help direct the client's presentation by asking specific questions?

___ 14. Did advocate ask the facility presenter what positive statements s/he could make about the client?

___ 15. If client wanted to accept treatment on a voluntary basis, did

- advocate convey this to the hearing officer?
- ___ 16. Did advocate explain any terminology used in the hearing which might have been unfamiliar to the client?
 - ___ 17. Did advocate make sure that all important issues that the client wanted to address were brought to the hearing officer's attention?
 - ___ 18. Did advocate summarize the most crucial points of his/her argument at the end of his/her presentation?
 - ___ 19. Did advocate explain the hearing decision to the client?
 - ___ 20. Did advocate present to the client his/her options if probable cause were found in a way that was not leading the client to a particular decision. For example:
 - ___ 21. Did advocate include the options to stay at the facility and work with his/her doctor; to go to court to try to get released from the hospital, or to think about it before deciding?

Attachment D

Hearing Officer Checklist

This is from the California Judges Benchguides produced by the California Center for Judicial Education and Research, LPS Proceedings.

§120.4

The certification review hearing shall be conducted by a court-appointed commissioner or a referee, or a hearing officer. Who is either a state qualified administrative law hearing officer, a medical doctor, a licensed psychologist, a registered nurse, a lawyer, a certified law student, a licensed clinical social worker, or a licensed marriage, family and child counselor with a minimum of five years experience in mental health.

Welf & I C §5250.1

1. Determine whether a person certified has filed a petition for habeas corpus relief. If so, the person is not entitled to a certification review hearing. Welf & I C §5256.
2. Review the notice of certification and determine whether it has been signed by the person in charge of the evaluation facility or his or her designee, and a physician, psychologist, nurse, or licensed clinical social worker who participated in the evaluation. Welf & I C §5251.
3. Determine whether the notice has been properly served on the person and sent to his or her attorney (often the public defender) or advocate or any other person designated by the certified person. Welf & I C §5253; see §120.31.
4. Determine whether the hearing is being held within four days of certification unless judicial review has been requested (see Welf & I C §§5275-5276), or the hearing has been postponed at the request of the person certified or his or her attorney or advocate. See Welf & I C §§ 5254, 5256.
5. Ask the person certified whether he or she has met with an attorney or patient advocate and discussed the commitment process and any questions the person may have about the certification process and review hearing. See Welf & I C §5255.
6. Determine whether the mental health facility has made reasonable efforts to notify family members or others designated by the certified person of the date and place of the hearing, or in the alternative, that the certified person

has requested that this information not be provided to family members.
Welf & I C §5256.4(c).

7. Inquire whether the certified person has recently taken any medication and, if so, what the probable effects are. Welf & I C §5256.4(a)(5).
8. Consider evidence from the designee of the director of the medical facility and the district attorney or county counsel, if appropriate. Welf & I C §5256.2.
9. Consider evidence presented from the certified person, including any written statements from family, friends, or others who indicate a willingness and ability to assist with the certified person's basic personal needs for food, clothing, or shelter. See Welf & I C §5250(d)(1)-(2). Resistance to involuntary commitment alone does not indicate evidence of a mental disorder, danger to self or others, or grave disability. Welf & I C §5256.4(e).
10. At the end of the hearing, determine whether there is probable cause to believe that the person is gravely disabled or a danger to self or others. Welf & I C §5256.6. If no probable cause is found, the court must either order the person released from involuntary detention, or, if the person consents, allow the person to remain voluntarily at the facility. See Welf & I C §5256.5.
11. If probable cause is found, order the person detained for involuntary treatment. Welf & I C §5256.5.

Attachment E

Interpreting Laboratory Reports

TEST	RANGE	Explanation
Cholesterol	< 240	Represents 1 of many risk factors for heart disease
HDL	45	(high density lipoprotein) good cholesterol – good for your heart
Creatin	< 1.2	Measures kidney function ¹
Iron/TIBC		Measures the body's iron stores
UIBC	92 - 365	
Transf. % Sat.	15 - 55	
TIBC	228 - 428	
Iron	35 - 160	
Albumin	58 - 74	(Blood Protein ABL) blood protein that measure nutrition ²
TSH	0.2 – 5.5	Thyroid stimulating hormone –measures thyroid activity. ³
White Cells	3.5 – 12.5	(WBC) is a screen for the presence of infection or inflammation in the body. ⁴
RBC	3.60 – 5.10	(Red blood cell count) is a test for anemia
Hemoglobin (After middle age)	14-18 gm/dl (12.4-14.9)	Test for anemia ⁵ Some labs do not differentiate between adult and middle age.
Hematocrit	42-54 %	Test for anemia ⁶
Platelets	140 - 400	One measurement of how well blood clots.
MCV	80 - 100	(Mean Corpuscular Volume) measures the size of red blood cells

¹ Determines whether kidneys are functioning normally. The creatinine-clearance test gauges the rate at which a waste, creatinine is “cleared” from the blood by the kidneys. Symptoms of kidney disease are – swelling (edema), nausea, and high blood pressure.

² Albumin is the main protein in human blood. This is part of a urine test. Some albumin in the urine is normal, too much albumin can be a sign of significant kidney disease, or it may simply be due to vigorous exercise.

³ A high number indicates an underactive thyroid. A low number indicates either an overactive thyroid or too much thyroid replacement is being taken.

⁴ White blood cells (WBCs) are cells, which circulate in the blood and lymphatic system and harbor in the lymph glands and spleen.

⁵ Hemoglobin is the oxygen-carrying pigment in the blood, the predominant protein in the red blood cells. Deficiency anemia results because iron is necessary to make hemoglobin, the key molecule in red blood cells responsible for the transport of oxygen. Can be caused by poor nutrition but there are some physical conditions that can also cause it such as ulcer or bleeding.

⁶ The proportion, by volume, of the blood that consists of red blood cells.