Letter to the Editor

Challenges experienced with the implementation of telecourt for psychiatric involuntary commitment hearings in the coronavirus disease 2019 pandemic

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The unprecedented outbreak of the coronavirus 2019 (COVID-19) pandemic has been a catalyst for an overnight transition to telehealth services across heath care systems. Remote communication of all types has been utilized to preserve the safety of healthcare providers and their patients, while continuing to maintain a semblance of normalcy. While people across demographics have needed increased health services, most health systems, particularly those dealing with underserved populations, are technologically ill-equipped.

The intersection of psychiatry and the legal system has been radically changed by the pandemic, with novel applications of telecommunication. In California, patients with serious mental illness who are determined to be a danger to themselves, others or are gravely disabled are often admitted involuntarily to an acute mental health unit under the Lanterman-Petris-Short (LPS) Act of California (1). Often, these patients lack an adequate support system, which is correlated with sustained improvement in patients' mental health (2). Subsequently, patients require significant disposition planning to ensure each patient has a safe recovery and the ability to consistently obtain outpatient mental health follow-up. Under the LPS act, involuntary hospitalization has regulatory oversight through Probable Cause (PC) hearings that are typically conducted onsite in the hospital by a court-assigned hearing officer. Any appeals to the hearing officer's decision to uphold the involuntary commitment and LPS conservatorship hearings are typically conducted at an offsite metal health court. The COVID-19 pandemic has pushed the boundaries of the legal system in implementing videoconferencing services for conducting involuntary commitment hearings for severely mentally ill patients. Utilizing videoconferencing services for hearings is cost-effective, resource-efficient, improves patient and staff safety and reduces hospital liability (3). The LA court system has implemented teleconferencing for the involuntary commitment hearings with adherence to social distancing and hospital infection control policies.

The implementation of videoconferencing for LPS conservatorship or writ hearings has been challenging due to a lack of infrastructure. First, the court does not have a streamlined videoconferencing system for a virtual court. Presently, the participants provide testimonies separately over a phone conference with the defense attorney, district attorney and a judge. This makes it difficult for the patient or physician to provide a rebuttal for each other's statements. Second, the lack of visual correlation of the patient's behavior with his/her statements interferes with the courts' ability to obtain a holistic picture. Behaviors that may otherwise be considered inappropriate in a courtroom setting are missed. Third, the restructuring of the courts to meet the social distancing demands has resulted in LPS hearings having inconsistent applications of Hearsay evidence. For example, some judges strictly adhere to the *People v. Sanchez* ruling to disallow hearsay evidence through expert testimony (4). This inconsistent application across various judges makes it difficult for testifying psychiatrists to foresee if any

other involved staff should be available to testify about their accounts of the patient's condition. Maintaining that prior relevant psychiatric history cannot be utilized for a patient's current clinical diagnosis undermines that past history is a consistent way to predict the future disease course (5). Finally, it is our experience that there is a general misconception that patients in the hospital are at a higher risk for COVID-19 likely leading to an unconscious bias to release the patients. These challenges have at times led to patients with severe mental illness and grave disability being prematurely released from involuntary commitment by the court. They become at risk for homelessness, worsening of their co-morbid medical diseases, relapse of substance use disorders and further psychiatric decompensation resulting in a vicious cycle of readmission or recidivism.

The above points lead to the argument that the LA Court System should be advanced technologically. The telecourt system is a cost-effective and safe method to conduct court hearings (6). Patients would not require walking restraints to prevent elopement and there is a decreased risk for injury to staff by a psychiatrically dysregulated patient. Although the changes in telemedicine regulations in response to COVID-19 has been incredible, this same innovation should be applied to the telecourt system, to best advocate for our patients. There are many positive lessons to be learned from the use of telecourt but it is unclear whether these lessons will carry forward in the long-term. The COVID-19 pandemic has been a radical global challenge and the sweeping regulatory and bureaucratic changes combined with the novel technological applications in order to best serve our patients presents for a unique opportunity to analyze the shortcomings of our current system and improve upon the field of psychiatry in a sustainable way.

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Footnote

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