The Los Angeles Solution

A summary of the stipulated judgment and permanent injunction in the case of Balderas vs. Pitchess, civil No. CA 000617 (Superior Court of Los Angeles County, 1980).

The 1980 consent judgment and injunction is a negotiated document which carefully balanced individual freedom against the control of communicable disease. It recognized the need to confine involuntarily such people as transients and alcoholics who are not able to complete a course of treatment for tuberculosis on an outpatient basis. By providing such persons with opportunity and considerable assistance to contest confinement, the highly detailed order minimized confinements.

The injunction stopped the practice of the defendants—Los Angeles County, the Sheriff, the Director of the Department of Health Services, and the Chief of the Tuberculosis Control Division—from confining anyone in penal facilities solely on the basis of an Order of Isolation issued for the involuntary confinement of a contagious tuberculosis patient (under Section 3285 of the local Health and Safety Code).

The second and predominant portion of the consent judgment established various procedural protections as prerequisites to any involuntary confinement under a Section 3285 Order of Isolation. The essential contents of an order and of "statements in support" of an order were spelled out. An "explanation of procedures and rights" to accompany each order was appended to the stipulated judgment. The time of service of each document was specified as was the patient's right to have such documents in a language he or she understands. The order and "statements in support" of it were to be kept for 3 years in the patient's file.

To assure comprehension of the confinement process, the judgment required that within 24 hours of detention a health services worker from the Tuberculosis Control Division explain the terms of the order, the statements in support of it, the "explanation of rights," the criteria for revision of an order and release, all in a language the patient understands. The translator's name was to be noted in the patient's medical file with findings on patient comprehension. If the patient did not understand, the health services worker was to obtain assistance promptly from others. If help was unavailable or ineffective, legal counsel was to be obtained for the patient without delay.

At the time of the explanation of patient rights, the health department worker was to see to it that the following rights were implemented: (*a*) patient inspection of medical records and production for the isolation hearing as requested; (*b*) witnesses made available, by subpoena if involuntary unless their testimony would be irrelevant or repetitious; (*c*) an attorney; (*d*) an independent medical expert; and (*e*) an interpreter. There could be no waiver of these rights unless a written certification of understanding of such waiver were prepared by the health department worker.

Absent a proper waiver, an order of isolation hearing was to be no sooner than 3 days and no later than 9 days after the ordered confinement. At the hearing, the patient was to have traditional due process rights, such as presenting evidence and confronting and cross-examining witnesses, all on the record. Witnesses were to attest in writing to the truth of their testimony. An introductory statement (attached to the consent judgment) was to be read to the patient at the hearing. In addition, the qualifications of the hearing officers who were to preside over these hearings were set out.

Most importantly, the consent judgment framed the issue to be determined at the hearing, and addressed by the order and "statements in support" of it, as *whether there is a reasonable cause to believe that an order of isolation is warranted* under Health and Safety Code Section 3285 *because the patient is* currently *infected*, has not completed a course of treatment *and would not reliably participate in voluntary treatment and release would constitute a probable threat to the public health.* (Emphasis added.)

On a finding of insufficient evidence to support detention, the patient would be released unless the health department indicated it would seek court review. Provision was made also for a second hearing with full protections upon request of the patient no more than 25 days after the first (or waiver thereof).

County court review of a hearing officer's decision to release a patient was to occur within 48 hours of that decision. To overturn it, the health department would have to show an abuse of discretion in the decision. Again, the patient would have a right to counsel. Either side could introduce proof of its position not previously available. If the court found for the patient, he or she would not be further detained under the order of isolation.

Even when the hearing officer decided in favor of detention, to maintain the confinement for an adequate treatment period, the health department was to file a petition for isolation in the County Court either 48 hours after a second order of isolation hearing resulting in detention of the patient, or within 50 days after the initial administrative hearing resulting in confinement. Due process rights, such as trial by jury, were again assured. These rights could be waived at an initial appearance of the patient but only in open court with a finding by the court that the rights were intelligently and voluntarily waived. Trial was to be set within 10 court calendar days of the initial appearance. Where a jury trial is held, to continue to confine a patient, 9 of 12 jurors have to find clear and convincing evidence that confinement is warranted under the above-cited criteria.

Provision was made for reimbursement of the county for counsel appointed to represent an indigent patient, should it subsequently appear that a patient had the means to do so. In addition, the procedure for determining fees for the attorneys participating in the stipulated judgment was set out in considerable detail.

Counsel for all the parties agreed to participate in training of hearing

officers and health services workers who inform patients of their rights.

Public interest attorneys for the plaintiffs retained a continuing duty to monitor and enforce the implementation of the stipulated judgment. To assist in this undertaking, the county was to prepare and maintain statistical records and reports for 3 years on (*a*) the number subjected to orders of isolation with socioeconomic data, (*b*) reasons for the duration of and termination of confinements, (*c*) the number treated by community workers, (*d*) the number housed in secure medical facilities, (*e*) the number referred to prosecution for violations of confinement orders, and (*f*) the number in the tuberculosis registry lost to supervision. In addition, the department of health services was to prepare semiannual summaries of all orders of isolation and all prosecutions for violations of such orders. If the above data were insufficient, any party could petition the court to inspect other material, such as the original orders or transcripts of hearings.

It was agreed that if during the 3 years after the stipulated judgment the number of prosecutions for violating Section 3285 detention orders in any 6-month period exceeded 15 percent of the orders, or more than 5 orders, then counsel for plaintiffs would have the right to demand, within 60 days, access to a licensed medical facility for secure confinement to reduce the necessity for criminal prosecutions and incarcerations. Similarly, if the percentage of tuberculosis patients lost to supervision were to exceed 20 percent of those in tuberculosis registry, then any party to the suit could demand secure confinements in licensed facilities for patients under Section 3285 orders. Otherwise, defendants were obligated to confine patients under the least restrictive conditions available, but consistent with the need for involuntary detention.

The remainder of the order pertained to assessments of and improvements to be made in treatment opportunities for the difficult-to-treat TB patient population, such as continuation of a program of outreach workers in clinics who were providing individual therapy to reduce the necessity of confinements. The assessment of this program was to include participation by counsel for all the parties to the agreement. The county and the director of tuberculosis control also agreed to study the feasibility of establishing a TB diagnostic and treatment clinic for homeless and transients in the downtown skidrow area. If appropriate, such a clinic was to be quickly established.

Finally, should disputes arise about application of the stipulated judgment and injunction, the parties agreed to attempt resolution by themselves before seeking judicial solutions.

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Tuberculosis Screening in Boston's Homeless Shelters

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A number of persons provided substantial help to the project described in this paper. Sue Weidhaas, RN, MS, and Barbara Thomas, RN, Massachusetts Department of Public Health, Tuberculosis Control Program, assisted in organizing the screening program. Doris Johnson, SM (AAM), MEd, Massachusetts Department of Public Health, Mycobacteriology Laboratory, performed mycobacterial cultures. Barbara Blakeney, RN, and Bob Richards, MSW, Health Care for the Homeless Project, and Barbara McInnis, RN, Pine Street Inn, served as liaison with participating shelters. Wilbur D. Jones, Jr., PhD, Mycobacteriology Branch, Centers for Infectious Diseases, Centers for Disease Control, performed phage typing.

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Synopsis

From February 1984, through March 1985, a total of 26 cases of tuberculosis (TB) were verified in homeless persons in Boston.

Fifteen cases were resistant to isoniazid (INH) and streptomycin (SM) and were most likely the result of a common source exposure to one or