Law Foundation OF SILICON VALLEY

Advancing Justice
Housing | Health | Children & Youth

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The Honorable Jim Wood, Chair, Committee on Health
The Honorable Mark Stone, Chair, Committee on Judiciary
California State Assembly
1315 10th St
Sacramento, CA 94249

RE: Joint Hearing: The Lanterman-Petris-Short Act: How Can It Be Improved?

The Law Foundation of Silicon Valley is a legal services non-profit that advances the rights of historically excluded individuals and families through legal services, outreach, community lawyering, and strategic litigation and advocacy. Our Health Program serves communities who are historically excluded from health systems including Black, Indigenous, Latino, Asian American Pacific Islander, other people of color, people who are LGBTQIA+, and people who are unhoused, focusing on health equity for all.

Under California law, each county must appoint patients' rights advocates with the responsibility to protect the rights of direct consumers of mental health treatment. As the Patients' Rights Advocates for Santa Clara County, we monitor inpatient facilities for compliance with the Lanterman-Petris-Short Act (LPS Act) and represent patients in civil commitment and capacity hearings in LPS-Act designated facilities. We appreciate the opportunity to provide written testimony to the Joint Information Hearing: The Lanterman-Petris-Short Act: How Can It Be Improved?

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1. The Law Foundation opposes all forms of involuntary treatment and systems that perpetuate involuntary treatment.

The Law Foundation opposes all forms of involuntary treatment. Competency, guardianship, and civil commitment proceedings deprive patients of their civil rights. Conservatorships and guardianships strip patients of their legal right to make daily decisions, leaving them vulnerable to abuse. The Law Foundation believes that patients should retain their full autonomy and rights. Indeed, the systems that interplay with ultimately leading to involuntary treatment are important factors in removing involuntary treatment as well.

1.1. Involuntary treatment destroys patient trust in the mental health system and leads to worse psychiatric outcomes.

We advocate replacing forced inpatient hospitalization with investment in free, community-based, long-term supportive systems of care. Mental healthcare is most effective when provided in a comprehensive and preventative fashion rather than when administered as an emergency response to a crisis. Many mental health conditions are chronic. Patients need long-term access to services and care that is flexible, specialized, and ongoing. Instead, patients are forced to spend days in involuntary treatment only to be released back into the same situation that they faced before hospitalization—without any long term support.

As the County's patients' rights advocates, we hear time and again that the prospect of being forced into treatment via the civil commitment system prevents consumers from voluntarily entering treatment. Indeed, forced treatment has been proven largely ineffective. When patients lose their liberty and are denied their choice of treatment, they lose trust in their provider and in the mental health system.

Contrary to a comprehensive and preventative healthcare plan, psychiatric hospitalizations, both involuntary and voluntary, increase the risk of suicide. In 2014, researchers at the University of Copenhagen found that admission to a psychiatric hospital resulted in a 44-fold increase in a patient's risk of dying by suicide. These findings were so robust that the researchers concluded that a depressed person treated in the community would be at lower

risk of dying by suicide than a non-depressed person undergoing psychiatric treatment in an emergency department.[1]

1.2. Involuntary treatment worsens racial inequities in policing and incarceration.

We also urge the Assembly to consider equity. Across the United States, police are the first responders to mental health crises. People with mental health disabilities are 16 times more likely to be killed in an encounter with the police.[2] And in the United States, law enforcement has a long history of inflicting violence and terror on communities of color—in particular, on Black communities. For example, more than half of disabled Black people have been arrested by the time they turn 28. This is double the risk of arrest for disabled white people.[3] The Assembly should keep these brutalized communities, especially their members who live with layered marginalized identities, at the forefront of the conversation as we move forward.

We acknowledge that involuntary treatment and the systems that perpetuate it, such as policing, are unlikely to cease overnight. We thus urge the Assembly to revise the LPS act to protect and preserve the civil rights and dignity of individuals receiving forced mental health treatment. Our recommendations are based on extensive experience working closely with consumers receiving involuntary treatment and rely on a patient-centered approach focused on dignity of risk, freedom of choice, and trauma-informed care.

[1] Robert Whitaker, *Medical Science Argues Against Forced Treatment Too*, Mad in America (March 19, 2016), https://www.madinamerica.com/2016/03/medical-science-argues-against-forced-treatment-too/#_edn1.

[2] German Lopez, *How America's Criminal Justice System Became the Country's Mental Health System*, Vox (October 18, 2016), https://www.vox.com/2016/3/1/11134908/criminal-justice-mental-health.

[3] Vilissa Thompson, *Understanding the Policing of Black, Disabled Bodies*, Center for American Progress, (Feb. 10, 2021), https://www.americanprogress.org/article/understanding-policing-black-disabled-bodies/.

2. The Assembly should amend the LPS Act.

California enacted the LPS Act in 1967 to "end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders."[4] The Act sought to protect the rights of people with mental illness by abolishing indefinite commitment, emphasizing voluntary treatment, and providing rights and legal remedies for people that were involuntarily detained.[5]

The LPS Act has been a step in the right direction to provide mental health patients with due process protections, including the right to a judicial hearing prior to an involuntary mental health hold.[6] But decades later, the LPS Act is in dire need of reform to further safeguard the protections afforded to patients and to ensure it actually meets its original purpose.

3. The Assembly should amend the LPS Act to give people the right to a voluntariness hearing.

Under the LPS Act, a person who is willing and able to accept voluntary treatment may not be involuntarily detained. WIC § 5250(c). But the LPS Act provides no process for ensuring that this requirement is met. A hearing to allow someone to accept treatment on their own terms is considered a voluntariness hearing. And it does not actually exist under the LPS Act.

In a voluntariness hearing, whether the patient is willing and able to accept voluntary treatment turns on questions of fact: the patient's candor, attitude towards treatment, trust in psychiatry, severity of symptoms, history of outpatient treatment, and history of voluntary inpatient treatment, among many others. Patients who contend that their physicians have wrongly labeled them unable or unwilling to accept voluntary treatment thus contend that those labels

[4] Disability Rights California, Understanding the Lanterman-Petris-Short Act, https://www.disabilityrightsca.org/publications/understanding-the-lanterman-petris-short-lps-act.

[5] Cal. Welf. & Inst. Code § 5001.

[6] Cal. Welf. & Inst. Code § 5256.5.

rest on "misleading factual premises."[7] It is precisely in such contexts that due process requires an opportunity to be heard.[8]

The Assembly should amend the LPS Act to provide voluntariness hearings. Santa Clara County has recognized the right of patients to have voluntariness hearings since 1994. Hearing officers consider "evidence and arguments relevant to whether the patient is willing and able to be a voluntary patient" and "issue a written decision giving the reasons for the[ir] determination."[9] And when the hearing officer finds that the patient is willing and able to be a voluntary patient, "the certification shall be discharged and the patient permitted to sign in as a voluntary patient."[10]

These voluntariness hearings have given many of our clients an opportunity to vindicate their right to treatment in the way "least restrictive of the[ir] personal liberty."[11] By codifying voluntariness hearings into the LPS Act, the Assembly will be ensuring that all patients in California are given that same opportunity.

4. The Assembly should amend the LPS act to include remedies for serial holds.

We have been frustrated to witness our clients being placed on serial 5150 (72 hour) and 5250 (14 day) holds during a single admission. The LPS Act currently sets the maximum amount of time a patient may be involuntarily detained: 17 days.[12] A single involuntary hold is already a severe deprivation of liberty, autonomy, and long-term well-being. A second involuntary hold during the same admission compounds those deprivations—and it violates the law.

Serial holds prevent our clients from working, force our clients to miss important life events such as weddings and funerals, and place our clients at risk of losing

[7] *Goldberg v. Kelly*, 397 U.S. 254, 268 (1970).
[8] *Id.* at 267–68.
[9] Santa Clara County Certification Review Hearings: Policy & Procedure Manual, § VIII.K (2008).
[10] *Id.*
[11] Cal. Welf. & Inst. Code § 5325.1(a).
[12] The 17 period includes the initial 72-hour hold, the 14-day hold, and any intervening periods of involuntariness. Cal. Welf. & Inst. Code § 5258.

their housing. Most importantly, serials holds continue the separation of our clients from their families and loved ones. The consequences are sometimes even more grave: one of our clients—after being placed on a second 5250 hold and told that she was not allowed to leave—uncapped her dialysis port, causing her to bleed out and the hospital staff to call a code blue. Patients should not be driven to such desperate acts by impermissible back-to-back involuntary holds.

Another client, V.K., was placed on serial holds in April 2021. V.K. accidentally fell into a body of water and was placed on an involuntary hold. The hearing officer found that V.K. did not meet the criteria for a 5250 and ordered his release. The hospital not only failed to release him—it placed him on a second 5250 hold and continued to detain him against his will. We investigated and successfully obtained V.K.'s release. V.K. continues to experience trauma from his illegal serial holds and continues to struggle to pay off the thousands of dollars he still owes to the facility for his improper involuntary detainment.

Violations such as these demand a remedy. These clients are only two of many who we have seen placed on serial holds. Despite the LPS Act's bar on serial holds, facilities have continued to involuntarily detain patients using serial 5150s and 5250s. The Assembly must amend the LPS Act to end this practice.

The LPS Act should mandate a procedural discharge for patients when a facility has placed them on a serial 5150 or 5250 hold. And facilities that place such holds should be penalized. Those penalties might include some combination of, for example, licensing investigations, a cause of action for patients placed on serial holds, and minimum statutory damages payable to the injured patient.

5. The Assembly should redefine "grave disability."

Under the LPS Act, grave disability is "a condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter."[13] This definition is vague and grants unfettered discretion. The Assembly should amend the LPS Act to give grave disability more specificity and to include procedural requirements that hospitals must follow when certifying a patient as gravely disabled.

[13] Cal. Welf. & Inst. Code § 5008(h).

5.1. The LPS Act's definition of grave disability grants unfettered discretion to hearing officers to hold patients who are able to survive safely in freedom.

The LPS Act provides no guidance for what "inability" to provide for basic needs entails, allowing for inconsistent and discriminatory application. Understaffed and overworked hospitals often base a certification of grave disability on a brief patient interview without time to investigate the patient's plan for care. Implicit and explicit bias compounds these problems, causing facilities to detain people from historically excluded communities for longer than people not from these communities. And hearing officers find that unhoused people are gravely disabled for that reason alone despite their ability to provide for themselves using community resources.

For example, our client D.S., a Black woman, was involuntarily held on a 14-day 5250 hold for grave disability. D.S. was a college student and single mother, managing classes and part-time work as a behavioral interventionist. She used Social Security, CalFresh, and housing vouchers to obtain food, clothing, and shelter. She used community outpatient mental services, including counseling and therapy. Despite D.S.'s record of caring for her basic needs, her physicians held her for grave disability.

5.2. The Assembly should amend the LPS Act's definition of grave disability to provide more specificity.

The Assembly should adopt a narrower definition of grave disability that gives more specificity. Alaska, for example, defines "gravely disabled" as: "[A] condition in which a person as a result of mental illness . . . is in danger of physical harm arising from such complete neglect of basic needs for food, clothing, shelter, or personal safety as to render serious accident, illness, or death highly probable if care by another is not taken."[14] Requiring a "complete neglect of basic needs" and the provision "to render serious accident, illness or death highly probable" would at least minimize the civil commitment of unhoused mental health consumers who can manage their basic needs even when they have trouble acquiring shelter.

[14] Alaska Stat. § 47.30.915(9)(A).

5.3. The Assembly should amend the LPS Act's definition of grave disability to include more procedural requirements.

The Assembly should also add procedural requirements for certifying an involuntary hold for grave disability. The LPS Act should mandate that a psychiatrist complete an affidavit detailing the reasons for recommending involuntary commitment, the evidence that the person is gravely disabled, and the person's mental health diagnosis. The psychiatrist should also be required to give information about medications, past psychiatric treatment, financial information, relatives, community services, recommended treatment plan, and discharge plan. These procedural requirements are already are used in conservatorship law and involuntary mental health holds should include the same requirements.

6. The Assembly should amend the LPS Act to define "danger to self" and "danger to others."

The LPS Act does not define danger to self or danger to others. This causes confusion, confers broad discretion, and leads to inconsistency in applying these standards. The Assembly should amend the LPS Act to include narrow definitions that work and reduce overbroad discretion.

6.1. The Assembly should amend the LPS Act to define "danger to self."

In Santa Clara County, "a person is considered a danger to self when he or she behaves in a manner or threatens to or otherwise indicates that he or she will behave in a manner that would result in his or her substantial injury or death. 'Danger to self' means a present danger. The dangerousness to self must be as a result of a mental disorder or impairment by chronic alcoholism."[15]

This definition prevents people from being detained who are not a present danger despite past suicide attempts or ideation. Many patients are placed on holds for danger to self because of behavior while intoxicated or following a drug overdose. Other patients have their mental health symptoms alleviated shortly after hospitalization. The requirement of "present danger" conforms to

[15] Santa Clara County Certification Review Hearings: Policy & Procedure Manual, § II.K (2008).

the hearing officer's duty to order release unless the person certified "*is* . . . a danger to himself or herself."[16] One appellate court reviewing a conservatorship agreed that people should not be detained based on predictions of their future behavior: "If LPS conservatorship may be reestablished because of a perceived likelihood of future relapse, many conservatees who would not relapse will be deprived of liberty based on probabilistic pessimism."[17]

6.2. The Assembly should amend the LPS Act to define "danger to others."

In Santa Clara County, "a person is considered a danger to others when he or she behaves in a manner or threatens to or otherwise indicates that he or she will behave in a manner that would substantially injure or kill another individual. "Danger to others" means a present danger. The dangerousness to others must be as a result of a mental disorder or impairment by chronic alcoholism."[18]

Like dangerousness to self, dangerousness to others is often a temporary state, frequently caused by intoxication or situational socioemotional stressors. When that temporary state abates, so too should involuntary detention, as the hearing officer must order release unless the person certified "*is* . . . a danger to others."[19]

7. The Assembly should raise the standard of proof for finding that a patient can be held on a 5250 hold.

The Assembly should raise the standard of proof in certification review hearings from probable cause to clear and convincing evidence. Probable cause is a low standard of proof.[20] It is incompatible with a serious deprivation of human rights, such as an involuntary hold.

In certification review hearings, probable cause requires specific and articulable facts, which taken together with rational inferences from the facts, "would lead a person of ordinary care and prudence to believe, or to entertain a strong

[16] Cal. Welf. & Inst. Code § 5256.5 (emphasis added).
[17] *Conservatorship of Benvenuto*, 180 Cal.App.3d 1030, 1034 n.2 (Cal. App. 1986).
[18] Santa Clara County Certification Review Hearings: Policy & Procedure Manual, § II.L (2008).
[19] Cal. Welf. & Inst. Code § 5256.5 (emphasis added).
[20] *Kaley v. United States*, 134 U.S. 1090, 1103 (2014).

suspicion, that the person detained is mentally disordered and is a danger to himself or herself or is gravely disabled."[21]

By contrast, in capacity review hearings, the legal standard is clear and convincing evidence.[22] This standard better protects people from erroneous deprivations of liberty. In 1978, the Supreme Court considered the standard of proof for involuntarily committing a psychiatric patient.[23] The Court held that the standard of proof was "clear and convincing evidence."[24] In so doing, the Court struck a balance between the interests of the individual and the state. To involuntarily detain patients on 5250 holds, that balance requires raising the standard of proof.

Although this case involved an indefinite commitment, the Court's reasoning should be applied to 5250 holds. Despite the hold being temporary, being held involuntarily for 14 days can cause people to miss paying rent or bills, leading to evictions, or to miss days of work, leading to job loss. It prevents people from taking care of their children, leading to losing custody. These collateral consequences are devastating. And to guard against them, a preponderance of the evidence standard would not be enough. A clear and convincing standard of evidence would better protect patients' rights and ensure that people are detained only as a last resort.

8. The Assembly should amend the LPS Act to prohibit or limit the use of seclusion, restraints, and involuntary medication.

The use of seclusion and restraints—both physical and chemical—is painful, humiliating, dehumanizing, and traumatizing. It leads to the neglect and abuse of already vulnerable patients. Using chemical restraints via emergency intramuscular injections violates patients' bodily autonomy and their right to choose their treatment as they are physically restrained and forcibly injected with sedating medications in their buttocks.

[21] *People v. Triplett* 144 Cal.App 3d 283 (Cal. App. 1983).
[22] *Riese v. St. Mary's Hospital and Medical Center*, 243 Cal. Rptr. 241 (Cal. App. 1987).
[23] *Addington v. Texas*, 441 U.S. 418.
[24] *Id.* at 432–33.

Eliminating seclusion and restraint increases the safety of hospitals for both staff and patients. In a 2004 study of Pennsylvania hospitals, researchers found that a hospital that had become "virtually free of seclusion and restraint saw a 67 percent decline in disabling injuries among patients and staff."[25] Other studies have shown that the "elimination of seclusion and restraint not only saves money but also improves client outcomes and staff working conditions."[26]

Because it is unlikely that hospitals will cease employing all forms of seclusion and restraints, we urge the Assembly to amend the LPS Act to remove the use of seclusion and restraints.

8.1. The Assembly should amend the LPS act to limit the time that patients can be secluded or placed in restraints.

The LPS Act contains no limits on the time that a patient can be placed in seclusion or restraints. Patients can spend days—even weeks—in seclusion or restraints during their hospitalization. California law already recognizes that such practices as harmful. For example, state law limits the amount of time that incarcerated people can spend in safety cells in prisons and jails. Patients who are involuntarily hospitalized should have the same protections.

8.2. The Assembly should amend the LPS act to require that hospitals collect and publish data on the use seclusion and restraints by race.

We have found that seclusion and restraints, especially chemical restraints via emergency medication injections, are disproportionately used on people of color. There is no requirement that hospitals provide data on the racial makeup of the patients who are secluded or placed in restraints. This lack of tracking is particularly concerning given the racist history of the United States healthcare system. It also obscures the disproportionate racial impact of criminalizing mental illness.

[25] Special Section on Seclusion and Restraint: Commentary: SAMHSA's Commitment to Eliminating the Use of Seclusion and Restraint | Psychiatric Services (psychiatryonline.org), https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.56.9.1139.
[26] *Id.*

8.3. The Assembly should amend the LPS Act to include remedies for patients who are illegally secluded or held in restraints.

We have seen many examples of seclusion and restraints that fail to meet legal requirements. Under the LPS Act, hospitals must ensure that less restrictive methods would be ineffective before they place a patient in seclusion or restraints. And seclusion and restraints can be used only to protect patients or staff from imminent danger. Assessing the imminence of a patient's behavior is a subjective measure and can lead to the improper use of seclusion and restraints on patients experiencing behavioral issues—such as yelling or making a mess.

Patients lack the ability to challenge the use of seclusion of restraints. To deter hospitals from continuing improper use, we urge the Assembly to adopt penalties for hospitals that improperly use seclusion or restraints. The subjective nature of the LPS Act's requirements for using seclusion and restraints allows hospitals to improperly use them against people of color disproportionately. Enforcing penalties against hospitals who abuse this system will provide accountability and give members of historically excluded communities a chance to seek recourse.

* * *

People with mental health disabilities are entitled to the same dignity, humanity, and civil rights that everyone enjoys. The Law Foundation thus opposes all forms of involuntary treatment, including coercive "voluntary" treatment mandated with the force of the court. Such treatment is not only largely ineffective—it also exacerbates existing racial disparities and traumatizes patients, eroding their relationships with mental healthcare providers. The same is true of seclusion and restraints.

If involuntary treatment is to continue, the Assembly should amend the LPS Act to recognize that those undergoing such treatment are entitled to as much dignity, respect, autonomy, and choice as possible under the circumstances. We provide these recommendations from our perspective as advocates who work every day with patients undergoing forced psychiatric treatment. And we do so with special consideration for the unique needs of historically excluded communities that are disproportionately represented in involuntary hospitalizations.

Our recommendations are concrete and practical. We are not looking to rewrite the LPS Act but instead to codify legislative intentions present in the original Act but not always realized in practice. Psychiatric care can be stigmatizing, and that stigma is increased tenfold in an inpatient setting. Locked psychiatric treatment inherently implies that psychiatric patients are incapable of making the "right" choices for themselves or are too dangerous and different to participate in community life. Providers must not only be careful to avoid perpetuating that stigma but must also ensure that they are considering their own biases when assessing and treating patients, especially those from historically excluded communities. Our recommended revisions to the LPS Act would advance that goal by reducing involuntary commitment and making it more humane.

We urge the Assembly to join us in serving and centering the civil rights of marginalized groups undergoing involuntary psychiatric treatment.

Sincerely,

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