California Association of Local Behavioral Health Boards and Commissions

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ISSUE BRIEF: LPS Act Reform

LANTERMAN PETRIS SHORT (LPS) Act — Reforming the LPS to improve CA's Mental Health

With thousands dying[1] and decompensating in California's streets and institutions, the relentless cycle between homelessness, hospitalization and the criminal justice system for unserved and underserved individuals with severe mental illness must stop. It is in the interest of the state of California, local communities and the individuals and families they serve to: **(1)** Reform the LPS Act; **(2)** Ensure the availability of requisite resources to reduce and minimize involuntary treatment.

RECOMMENDATIONS

1. **Requisite Resources**: Provide meaningful access to behavioral health treatment appropriate for each person's specific needs. Improving the quality and quantity of services will significantly reduce the revolving doors of incarceration, re-hospitalization and homelessness. See next column for listing of Requisite Resources.

2. **Consistent administration** of the LPS Act, to include identification of individuals who meet the criteria of **"gravely disabled".** Being "gravely disabled" means that someone is no longer able to provide for their own food, clothing, or shelter due to severe substance use disorder (including alcohol use disorder) or mental health issues. (WIC § 5008(h)). Someone who cannot or will not try to find food or shelter as a direct result of a mental illness or substance use disorder likely falls under the criteria of "gravely disabled."

3. **Physical Health**: Allow LPS Conservators to manage physical health conditions (as is currently allowable in the probate[2] setting based on the person's incapacity to give informed consent.)

REQUISITE RESOURCES

1. **Engagement Tools** w/Peer Providers Embedded
   - Comprehensive Outreach
   - Shared Decision Making
   - Psychiatric Advance Directives [3]
   - Assisted Outpatient Therapy (AOT) [4] / Laura's Law [5]
   - Conservatorship (As a last resort.)
2. **Comprehensive Community Services** that are accessible, integrated, recovery-focused, trauma-informed and culturally competent, addressing:
   - Peer Providers Embedded
   - Housing (including Board & Cares [5])
   - Mental Health
     - Prevention/Early Intervention
     - Psycho-Social Services
     - Medication Management
     - Crisis Care Continuum (See Issue Brief)
     - Hospitalization (As a last resort.)
   - Physical Health/Behavioral Health Integration
   - Public Guardians & Conservators
     - Appropriately trained
     - Manageable caseloads
   - Substance Use
   - Vocational / Behavioral Health Integration
3. **Inter-Agency Collaboration** between hospitals, jails, prisons and behavioral health departments (county and commercial) that include:
   - Information Sharing
   - Discharge/Aftercare Plans
   - Warm hand-offs

SAMHSA Policy Guidelines—Page 2 LPS Process Outline—Page 4

POLICY GUIDELINES For INVOLUNTARY COMMITMENT

from SAMHSA's 2019 "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice"[7]

1. Effective Treatment	Civil commitment, whether inpatient or outpatient, should be reserved for those reliably diagnosed with a serious mental illness for which there is available treatment that is likely to be effective. Commitment's purpose must be treatment, and need for treatment is an essential requirement for commitment.
2. Inability to Engage Voluntarily	If the person is willing and able to engage with services voluntarily, he or she should not be committed. In deciding whether to order commitment, courts should consider the preferences of the person and the degree to which the person understands the nature of his or her mental illness and the likely effect of treatment.
3. Risk of Harm for Person or Others	A person should not be subject to inpatient commitment unless, without a hospital level of care, the person will be at significant risk, in the foreseeable future, of behaving in a way, actively or passively, that brings harm to the person or others. Unless the serious mental illness for which treatment is needed places the person at risk for harm, inpatient commitment should not be used. Risk for harm, however, should not require risk of violent behavior. If an individual is at risk for injury, illness, death, or other major loss solely due to mental illness symptoms such as an inability to exercise self-control, judgment, and discretion in the conduct of his or her daily activities, or to satisfy his or her need for nourishment, personal or medical care, shelter, or self-protection and safety, he or she should be committable.
4. Outpatient Commitment is Preferable	If a less restrictive alternative to inpatient commitment is available, including outpatient commitment, inpatient commitment should not be ordered. If, with the help of family, friends, or others who are available and willing to help, a person is capable of remaining in the community without presenting risks associated with need for treatment, he or she should not be subject to inpatient commitment.
5. Outpatient Commitment Requirements	A person should not be subject to outpatient commitment unless (i) he or she meets the standard for inpatient commitment, but may be served in a less restrictive setting, or (ii) without the treatment proposed, and other supports the court might order, it is reasonably predictable that the person will experience further disability or deterioration to a degree that, in the foreseeable future, the person will meet the inpatient commitment standard. Because commitment under this second prong (i.e., on grounds of further disability or deterioration) addresses risks of harm that are less immediate, respect for personal autonomy may require an additional finding of impairment in the person's understanding of the nature of his or her mental illness and the treatment proposed, including the potential risks and benefits of such treatment and the expectable consequences if commitment is or is not ordered. Full legal incompetency, however, should not be required.
6. Due Process	Legal proceedings should accord due process protection, including prompt notice of rights, assignment of counsel, and an opportunity to challenge commitment before a judge or other judicial authority without unreasonable delay.
7. Minimize Trauma	Commitment practices should respect the privacy and dignity of the individual. Every effort should be made to minimize trauma. If law enforcement agencies are responsible for transporting individuals proposed for or under order of commitment, they should assign plainclothes officers in unmarked cars, whenever possible. Shackles and other restraints should be used only if necessary, never as a matter of routine.

POLICY GUIDELINES For INVOLUNTARY COMMITMENT *Continued*

from SAMHSA's "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice"[8]

8. No Incarceration	Unless already incarcerated for a criminal offense, or facing criminal charges, no candidate for commitment should be detained in a jail or other correctional facility pending commitment, and no person who has been committed should be placed in a correctional facility for treatment services.
9. Prevention Upon Release	Jail and prison authorities, when planning for the release (re-entry) of an inmate with a serious mental illness, should consider whether to initiate commitment proceedings (inpatient or outpatient), depending on the inmate's needs and the likelihood that the inmate will cooperate with treatment once released. Such authorities likewise should be attentive to the needs of inmates while incarcerated and, when faced with an inmate whose needs cannot be met in the institution, should take whatever steps are provided by law for the inmate's transfer or commitment to a more therapeutic setting.
10. Prompt Termination of Commitment	Civil commitment should never be used solely for preventive detention or community control. Treatment staff should have the authority to terminate commitment without the court's authorization and should terminate commitment as soon as the individual progresses to the point where he or she no longer meets commitment criteria. No court should insist that a hospital or other treatment provider retain an individual in services at a level of care that the hospital or provider believes is unnecessary. Before terminating an individual's commitment, treatment staff should arrange appropriate services and supports for the individual in the community.

MANDATORY CIVIL PROCESS TO INITIATE LPS CONSERVATORSHIP
(from CA WIC and San Francisco LPS Report 2019) [8]

Patients can contest holds at any time and be placed at lower levels of care at any time, if appropriate.

Psychiatric Emergency Services (PE) or other acute setting initiates or receives patients on **5150 Hold (72 Hours)**	• 5150 hold: for patients deemed to be gravely disabled and a danger to themselves and/or others • If patient stabilizes within 72 hours, patient is discharged. • If 5150 hold expires & treating psychiatrist determines patient is still gravely disabled, can initiate 5250 hold for up to an additional 14 days. Patients who appear to need a 5250 hold are scheduled for admission to the acute inpatient unit. • If patient stabilizes, patient is discharged.
Acute inpatient initiates **5250 Hold (Additional 14 days)**	• If 5250 hold expires and patient has not stabilized, can initiate 5270 hold for up to 30 days • Can refer patients to Public Conservator for temporary conservatorship at this stage or at any point during or after the initial 5150 hold • If patient stabilizes, patient is discharged.
Acute inpatient initiates **5270** Hold (Additional 30 days) If psychiatrist determines patient is still gravely disabled, refers patient to the Public Conservator to determine if a temporary conservatorship is appropriate (**5352.1 status**)	• If 5270 has expired or close to expiration and patient has not stabilized, can refer to Public Conservator for temporary conservatorship determination • Public Conservator investigates whether patient meets gravely disability criteria • If patient stabilizes or does not meet grave disability criteria, patient is discharged.
(**5352.1**) Public Conservator investigation finds grave disability. District Attorney petitions the Superior Court to grant temporary conservatorship (Additional 30 days)	• If Superior Court agrees, Court grants temporary conservatorship of 30 days, and can extend up to six months. The patient can be placed in the clinically appropriate level of care pending the permanent conservatorship hearing. • If Superior Court denies petition for temporary conservatorship, patient is discharged.
5008(h)(1)(a) hearing for one year conservatorship establishes permanent conservatorship	• If Superior Court denies petition for permanent conservatorship, patient is discharged. • If Superior Court approves petition, the patient is placed in the clinically appropriate level of care • Public Defender represents patients at hearings for permanent conservatorship and City Attorney represents Public Conservator & DPH • Annual psychiatric evaluation to determine readiness for discharge

End Notes:

1. https://streetsensemedia.org/article/there-are-literally-thousands-of-people-dying-homeless-on-the-streets-of-america/
2. **Probate Conservatorships**: LPS conservatorships differ from probate conservatorships. California's Probate Code (Division 4, Part 3, Section 1800) authorizes the local Superior Court to appoint a conservator for adults who are unable to provide for their basic needs of food, clothing, and shelter, and/or manage their personal finances due to dementia or physical disabilities.
3. **Psychiatric Advance Directives (PADs)** are legal documents, drafted when a person is well enough to consider preferences for future mental health treatment. PADs allow appointment of a health proxy to interpret preferences in a crisis, and the PAD is used when a person becomes unable to make decisions during a mental health crisis.
4. **Assisted Outpatient Treatment (AOT):** From CA's Department of Health Care Services 2018-19 Report highlighted:
    - **Hospitalizations were reduced by a 33 percent change** during AOT, as compared to prior to the program. All counties reported a decrease in the number of days hospitalized, frequency of psychiatric hospitalizations, and/or crisis interventions per individual.
    - **Law enforcement contacts were reduced by a 43 percent** change during AOT, as compared to prior to the program. Five counties reported all participants avoided law enforcement contact while receiving services. Four of the six counties that reported incarcerations of participants during AOT, noted reductions in the number of days incarcerated per individual.
4. **Laura's Law:** [Important Note: Research evidence has shown very little correlation between mental illness and any violent behavior.[7]] Signed into law in 2002, Laura's Law was adopted by the state Legislature after a man with mental illness fatally shot Laura Wilcox, a 19-year-old volunteer at a Nevada County mental health clinic. The legislation allows each county in the state to decide whether to adopt the provision. To qualify for Laura's Law, an individual must have a serious mental illness that resulted in a psychiatric hospitalization or incarceration twice in the previous three years or resulted in violent behavior within the past 48 months. While outpatient treatment can be ordered, medication cannot. Laura's Law is designed specifically to help individuals with mental illness who suffer from a condition known as "anosognosia," a lack of awareness of their mental illness. 2020 legislation, AB 1976 requires counties to participate in Laura's Law unless they opt out.
5. See CALBHB/C's Issue Brief: Adult Residential Facilities (ARFs)
6. "While an estimated 18.3 percent of Americans suffer from some form of mental illness, only about 4 percent of community violence is attributable to psychopathology per se (Swanson, 1994)." Substance Abuse and Mental Health Services Administration [SAMHSA], 2016 "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice", SAMHSA, 2019, page 18.
7. SAMHSA "Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice": Practical Tools to Assist Policy Makers in Evaluating, Reforming and Implementing Involuntary Civil Commitment: Policy Guidelines for Involuntary Commitment", pages 32 and 33
8. City & County of San Francisco Policy Analysis Report Re: Review of LPS Conservatorship in San Francisco, Page A-6