The Lanterman-Petris-Short Act - Involuntary Commitment Act of 1967

The Lanterman-Petris-Short Act, often abbreviated LPS, concerns the involuntary civil commitment of individuals for psychiatric treatment in California. Since the passage of this involuntary commitment law, there have been significant changes in the mental health delivery system, and the law is now being interpreted in a manner that adversely impacts hospitals and their emergency departments.

Although numerous efforts have been undertaken in the last decade to make the law “work,” these efforts have failed to improve the fragmented and inconsistent application of the law and have placed additional unfunded burdens on hospitals.

Historical Overview

The intents of the LPS Act were to end the inappropriate and indefinite commitment of mentally disordered persons; to provide prompt evaluation; to guarantee and protect public safety; to safeguard individual rights through judicial review; to provide individualized treatment, supervision and placement services; to encourage the full use of all existing agencies, professional personnel and public funds to prevent duplication of services and unnecessary expenditures and to protect mentally disordered persons from criminal acts.

In the four decades since the enactment of the original LPS Act, much has changed in how care is delivered to individuals with mental illness in California. In 1991, a major change occurred with the enactment of the Bronzan-McCorquodale Act (Chapter 89, Statutes of 1991), referred to as “realignment.” Realignment transferred financial responsibility for most of the state’s mental health care from the state to local governments. The core principle under realignment was to provide expanded discretion and flexibility to counties. From 1995 through 1998, there was also a major shift in county obligations within the Medi-Cal program. In order to provide counties more flexibility in the use of state funding, and to enable more integrated and coordinated care, the state developed a plan to consolidate the two Medi-Cal funding streams for mental health. A decision was made to “carve out” specialty mental health services from the rest of Medi-Cal managed care, making California’s Medi-Cal mental health program entirely managed by local government.

As realignment and consolidation was taking place, the number of community hospitals accepting individuals in need of involuntary LPS care (“designated” facilities) decreased dramatically. At the same time, the five state hospitals operated by the California Department of Mental Health (DMH) were accepting fewer and fewer community referrals unless the individual was committed by court action or in connection with criminal proceedings.
Finally, the passage of the federal Emergency Medical Treatment and Active Labor Act (EMTALA) in 1996 did not consider the impact of California involuntary treatment laws on hospitals and has resulted in a growing dependence on hospitals as the treatment provider of last resort, regardless of a hospital’s capacity, capability or competency to care for this population.

**Current State of Affairs**

Today, California’s local mental health delivery system relies on a complex and shifting patchwork of federal, state and local funds and varies dramatically from county to county and from year to year, based on the policy and the political landscape at all levels of government. In many communities, an increasing number of individuals with mental illnesses are becoming homeless or incarcerated with many others remaining untreated or under-treated. This will be exacerbated as the state attempts to meet its court-ordered obligation to relieve overcrowding in state prisons and expands coverage to individuals formally uninsured.

The enactment of the federal Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008, the federal Patient Protection and Affordable Care Act of 2010 and the implementation of California’s Medi-Cal Section 1115 “Bridge to Recovery” Demonstration Waiver are adding to the complexity.

With each county having unique infrastructure, program design and administration, there is significant diversity in the level and types of mental health services available. For example, in California, 25 of 58 counties have no inpatient psychiatric services and 44 counties have no child/adolescent inpatient psychiatric facilities. This has led to an increased and often inappropriate dependence on hospital emergency rooms (often the only 24/7 service available) to become the default psychiatric services provider. This is occurring without regard to a hospital’s county-determined, involuntary designation status or their ability to care for the involuntary patient population.

Hospitals in some areas of the state have seen a 400 percent increase in the past year in the number of individuals with psychiatric disorders being seen in their emergency departments. Some hospitals have been forced to admit patients with acute psychiatric needs to their medical floors while awaiting placement in a facility providing psychiatric services. This places hospitals in an untenable situation of violating both their licensing laws and the civil rights of the patient.

During the writing of the LPS Act in 1967, a locally funded and provided community mental health system was never envisioned. As a result, no legal mechanisms were established to ensure those individuals who are too ill to accept or access mental health treatment would be compelled to do so. Thus, these individuals have become the frequent users of both inpatient psychiatric services and hospital emergency rooms. They are the “revolving door” patients with short-term usage of expensive hospital services as their primary locus of treatment. Once discharged from the hospital, these individuals frequently decompensate rapidly and either end up back at the hospital or become a threat to public safety. With the reduction in involuntary acute care beds, emergency rooms and jails have become the treatment settings of last resort. Mechanisms must be developed so that these individuals can be resolutely treated in the community rather than continue to cycle through the system.
Counties are also liberally interpreting the involuntary commitment laws – the LPS Act – to meet the local infrastructure needs of law enforcement, emergency transportation providers, county mental health departments, judicial services and community treatment providers. This has led to wide variations in application of the law from county to county, from city to city and even from hospital to hospital. All too often, these interpretations are to the detriment of patients, hospitals and the staff caring for them and may not be protecting the patients’ civil liberties or providing equal and consistent protections as prescribed in law.

Given the importance of ensuring that hospitals and their emergency departments are available to those in need of life-saving treatment, we must efficiently use our limited resources. It is well documented that failing to provide adequate mental health care will lead to higher social, personal and economic costs. The criteria in California’s LPS laws must be updated to incorporate current medical science regarding mental illness; correspond more closely with the Medi-Cal definition of “medical necessity” and provide treatment before unnecessary social, criminal justice and/or medical consequences occur.

For More Information:
www.calhospital.org/overview/lanterman-petris-short-lps-act

Contact:
Sheree Kruckenberg
Vice President, Behavioral Health
California Hospital Association
916-552-7576
skruckenberg@calhospital.org