February 17, 2023

Via TrueFiling

Chief Justice Patricia Guerrero and Associate Justices
California Supreme Court
350 McAllister Street
San Francisco, California 94102-4797

Re: *Disability Rights California v. Gavin Newsom*, No. S278330

Dear Chief Justice Guerrero and Associate Justices:

The Law Foundation of Silicon Valley and the California Association of Mental Health Patients' Rights Advocates (CAMHPRA) submit this letter in support of Disability Rights California's (DRC's) petition for writ of mandamus. Under California Rules of Court 8.500(g), we ask that you grant the petition and rule that the Community Assistance, Recovery, and Empowerment (CARE) Act violates the California Constitution.

I. Interest of the Law Foundation of Silicon Valley Foundation and California Association of Mental Health Patients' Rights Advocates (CAMHPRA)

The Law Foundation of Silicon Valley is a legal services non-profit that advances the rights of historically excluded individuals and families in Santa Clara County through direct legal service, community and movement lawyering, strategic advocacy, and educational outreach. Our Health Program serves communities who are historically excluded from and marginalized by health systems, including Black, Indigenous, Latinx, Asian American Pacific Islander (AAPI), other people of color, LGBTQIA individuals, people living with disabilities, and unhoused individuals, with a focus on health equity for all. The Health Program also includes Patients' Rights Advocates (PRAs), who conduct some of the most challenging and vital work in California's mental health system by protecting the civil rights of individuals with mental health disabilities.

Joining the Law Foundation's letter is CAMHPRA, a statewide organization composed of patients' rights advocates, private and public interest attorneys, consumers of mental health services, and representatives from other advocacy organizations in each of California's counties. CAMHPRA is dedicated to protecting and advancing the legal rights and treatment interests of individuals with mental health disabilities.

California PRAs have codified legal duties to represent mental health clients in administrative review hearings related to short-term, involuntary civil commitments and the right to refuse

psychiatric medications. PRAs also have a wide range of other responsibilities, including investigating patients' rights complaints, educating patients about their legal rights, and advocating for systemic changes to improve the quality of care for all patients. In fulfilling their duties, PRAs come into daily contact with clients detained under mental health holds, from 72-hour holds to permanent conservatorships. As such, both of our organizations are in a unique position to comment, on behalf of our clients, on the application, constitutionality, and ramifications of enacting CARE Court.

II. Purpose of the Lanterman-Petris-Short (LPS) Act and *Riese v. St. Mary's Hospital and Medical Center*

On July 1, 1972, the Lanterman-Petris-Short (LPS) Act went into effect in the State of California. Of its seven articles of intent, the first was to end the inappropriate, indefinite, and involuntary commitment of individuals with mental health and substance abuse disorders. The Act effectively ended the vast majority of involuntary commitments by establishing a civil commitment system, including judicial review, with a focus on prioritizing patient autonomy and rights. Before LPS enactment, people with mental health disabilities were warehoused in asylums, and criminal defendants had more rights than did mental health consumers in hospitals.

The landmark *Riese v. St. Mary's Hospital and Medical Center* 1989 case determined whether civilly committed mental health patients could refuse the administration of antipsychotic medication absent a judicial determination of incompetence. The Court held that, "Reasonable minds can perhaps differ on the question whether involuntarily committed mental patients should be presumed incompetent to make treatment decisions. However, such a presumption was demonstrably thought unwise and prohibited by those who enacted LPS. Accordingly, we hold that, absent a judicial determination of incompetence, antipsychotic drugs cannot be administered to involuntarily committed mental patients in non-emergency situations without their informed consent."[1] Both the LPS Act and the *Riese* case are the cornerstones of PRAs' administrative hearings.

III. What CARE Court seeks to accomplish and why it falls short

CARE Court seeks to force court-ordered mental health treatment on patients with schizophrenia, substance use disorders, and other mental health conditions. The CARE process begins when a family, county or community-based social services member, behavioral health provider, or even a

[1] Riese v. St. Mary's Hospital & Medical Center (1987) 209 Cal.App.3d 1303, 1320 [271 Cal.Rptr. 199.

first responder, files a petition with the Court. The Court then reviews the petition and decides if the patient meets eligibility criteria.

A. CARE Court standards violate precedents that require people to presently meet civil commitment criteria.

Under the current LPS legal framework, patients can be held in facilities involuntarily if they are *presently* a danger to themselves, others, or gravely disabled. The CARE Act eligibility criteria differs. Courts will order individuals into involuntary outpatient treatment if they are: "*Unlikely* to survive safely in the community without supervision and the person's condition is substantially deteriorating," or "in need of services and supports in order to prevent a relapse or deterioration that would be *likely* to result in grave disability or serious harm to the person or others."[2] The CARE Act provides no clear definition of what it means for a person to "likely" meet the criteria for CARE Court in the future. As such, patients and their advocates will face an impossible standard when trying to defend their rights to autonomy, choice, and personal freedom.

CARE Court's elimination of the "presentness" legal standard flouts established precedent: *Conservatorship of Benvenuto.*[3] In *Benvenuto*, a medical witness testified that although a conservatee was no longer gravely disabled, if he lived with his mother as proposed, he would "cease taking his medication" and "would be likely to regress and become gravely disabled."[4] The appellate court rejected such speculation and ruled: "If [an] 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."[5]

This was not a standalone finding. *Conservatorship of Neal* similarly ruled that to impose a conservatorship based on likelihood of relapse "could deprive the liberty of persons who will not suffer such a relapse solely because of the pessimistic statistical odds."[6] The Appellate Court has repeatedly ruled that a deprivation of rights based upon conjecture is unconstitutional.

B. CARE Court lasts longer than conservatorships, yet provides less due process.

CARE Court's serious lack of due process is obvious when considering conservatorships. Conservatorships last for one year and automatically end unless the conservator goes to court to

---

[2] *See* Cal. Welf. and Inst. Code §5972(d) (emphasis added).
[3] *See Conservatorship of Benvenuto*, 180 Cal.App.3d 1030 (1986).
[4] Id. at 1033-34.
[5] Id. at 1034 n. 2.
[6] *See Conservatorship of Neal*, 190 Cal.App.3d 685 (1987).

renew it. Unlike conservatorships under the Lanterman-Petris-Short Act, CARE Court can last for up to two years based on mere speculation and can be initiated by numerous parties, including those who do not qualify to initiate a conservatorship. Here, the risk of needlessly depriving people of their liberty could not be greater.

Detaining people who are not presently a danger to themselves, others, or gravely disabled, and forcing them into court-ordered evaluation and proceedings, is akin to a warrantless arrest. Probable cause for such an arrest applies only in criminal cases. In evaluating probable cause, "[t]he task of the issuing magistrate is simply to make a practical, commonsense decision whether, given all the circumstances set forth in the affidavit before him, including the 'veracity' and 'basis of knowledge' of persons supplying hearsay information, there is a fair probability that contraband or evidence of a crime will be found in a particular place."[7] Thus, this seizure of individuals will act to "criminalize," and further stigmatize mental health consumers, which would be contrary to the Court's goal of supporting and assisting individuals with mental health treatment.

C. CARE Court does nothing to address the real problem: lack of housing.

Even as a matter of practicality, CARE Court falls far short in its goals. CARE Court does nothing to address severe service gaps in county mental health systems. For example, CARE Court does not provide permanent, stable housing; it only directs public resources to be spent on a court process rather than on evidence-based treatment programs. Housing is an important social determinant of health. It is commonly believed that people with untreated mental health issues can easily become unhoused. In reality, it is the unavailability of stable housing that forces mental health consumers to become unhoused and struggle to engage with treatment, rather than the mental health issue itself. And as a result of homelessness, people face an increased risk of mental health conditions, infectious diseases, violence, and substance use, among other things.[8] If we want to support mental health consumers, housing—not mandated treatment—should be the priority.

D. CARE Court is yet another legal mechanism for forcing people into treatment—an ineffective practice that stigmatizes mental health consumers and that even aggravates existing psychiatric symptoms.

CARE Court is legal coercion, and thus expands forced treatment. Forced treatment has been proven largely ineffective for mental health consumers because the loss of liberty and autonomy in decision-making harms the relationship consumers have with their healthcare providers and the

[7] *Ilinois v. Gates*, 462 U.S. at 238 (1983).

[8] Brown, L (2021). How can housing influence health? *Medical News Today*. How can housing influence health? (medicalnewstoday.com).

mental health system as a whole. The quality of the relationship between a service provider and a client is widely recognized as playing a key role in treatment adherence, symptom reduction, medication adherence, outcome of psychotherapy and psychosis treatment, and quality of life.[9]

Literature also suggests that mandated clients are more resistant to therapy than voluntary clients. We often hear that the stigma related to mental health treatment, and the prospect of being forced into treatment, prevents consumers from seeking assistance and voluntarily entering treatment. As both utilization of mental health resources and treatment adherence are decreased due to stigmatization, forced treatment can indirectly promote the aggravation of psychiatric symptoms.

The Well Being Project, which conducts research as supported by the California Department of Mental Health, discovered that 55% of patients who had been treated by force rather than by choice directly avoided any and all further treatment for mental health or even emotional issues. Their research also showed that forced treatment destroys the essential patient/therapist relationship.[10] Advocates routinely hear patients report severe trauma from forced hospitalizations and care, particularly if they are subjected to restraints, seclusion, or injections of emergency medications against their will. Patients report such intense fear from being forcibly placed back into the healthcare system that the mere thought causes them to have suicidal thoughts. By the State reinforcing a fear-based model of care, reminiscent of the days prior to the LPS act, voluntary patient engagement will decline and as a result of CARE Court's enactment, there will be less desirable patient outcomes for *all* interested parties–including medical providers and the State.

IV. CARE Court will disproportionately burden historically excluded communities.

CARE Court will disproportionately burden historically excluded communities including Black, Indigenous, and other people of color (BIPOC), LGBTQ+, and people experiencing homelessness. These communities face barriers to economic stability caused by discrimination, systemic racism, and intergenerational poverty. Stressors—police brutality, trauma, and discrimination, among others—impact their mental health.

CARE Court will perpetuate race disparities, hurt BIPOC communities, and deny them their right to autonomy over their treatment. Compared to white people, BIPOC communities have less access

[9] Hatchel, H., Vogel, T., & Huber, C. (2019). Mandated Treatment and Its Impact on Therapeutic Process and Outcome Factors. *Frontiers Psychiatry*, *10* (Sec. Forensic Psychiatry). https://doi.org/10.3389/fpsyt.2019.00219
[10] Zinman, Sally, and Delphine Brody. "AB 1421 ('Laura's Law') Implementation: Why Oppose It." Editorial. *California Network of Mental Health Clients* 2012: n. pag. Print.

to mental health services and are more likely to receive lower quality care when they do receive services.[11] Racial bias, mistrust, and lack of cultural competency, all contribute to the overdiagnosis and misdiagnosis of schizophrenia in Black people. Black people are three to four times more likely to be diagnosed with schizophrenia than white people.[12] By requiring a CARE Court client to have a diagnosis identified in the class of schizophrenia spectrum and other psychotic disorders, the CARE Act will disproportionately impact Black people.[13]

Research also shows disparities in involuntary mental health holds and assistive outpatient treatment. Patients of color are significantly more likely to experience involuntary psychiatric hospitalization than white patients.[14] A Black person has a five times greater chance of being placed in outpatient commitment than a white person.[15] People who are unhoused also will be disproportionately referred to CARE Court, as nearly 25% of California's unhoused residents have a severe mental illness.[16] The CARE Act could strip thousands of unhoused people of their right to make decisions regarding their mental healthcare. Coercing people into treatment because of their housing status or their diagnosis, rather than their actual abilities, runs contrary to legislative intent and will have a disparate, discriminatory impact. CARE Court would also fail to address the critical social and environmental determinants of health – such as unaffordable housing, poverty, systemic racism, and incarceration – which contributes to mental health hospitalizations in the first place, especially for communities of color and other historically oppressed communities.

Mental health consumers experience immense societal stigma, leading to discrimination, criminalization, and lack of access to mental healthcare, especially in BIPOC and immigrant communities. As described above, being forced into mental health treatment against one's will can be traumatizing and can cause people to lose trust in mental health professionals. Communities of color are more likely to have negative experiences with the judicial system and may find a judge's

---

[11] McGuire TG, Miranda J. New evidence regarding racial and ethnic disparities in mental health: policy implications. Health Aff (Millwood). 2008 Mar-Apr;27(2):393-403. doi: 10.1377/hlthaff.27.2.393. PMID: 18332495; PMCID: PMC3928067.

[12] Schwartz RC, Blankenship DM. Racial disparities in psychotic disorder diagnosis: A review of empirical literature. World J Psychiatry. 2014 Dec 22;4(4):133-40. doi: 10.5498/wjp.v4.i4.133. PMID: 25540728; PMCID: PMC4274585.

[13] CARE Act

[14] Shea T, Dotson S, Tyree G, Ogbu-Nwobodo L, Beck S, Shtasel D. Racial and Ethnic Inequities in Inpatient Psychiatric Civil Commitment. Psychiatr Serv. 2022 Dec 1;73(12):1322-1329. doi: 10.1176/appi.ps.202100342. Epub 2022 Aug 12. PMID: 35959533.

[15] Swanson, J., Swartz, M., Van Dorn, R. A., Monahan, J., McGuire, T. G., Steadman, H. J., & Robbins, P. C. (2009). Racial disparities in involuntary outpatient commitment: are they real?. *Health Affairs*, *28*(3), 816-826.

[16] *See* pbs.org/newshour/nation/gov-gavin-newsom-proposes-court-ordered-mental-health-treatment-for-homeless-people https://www.nationalhomeless.org/factsheets/Mental_Illness.pdf

involvement in their mental health treatment off-putting, and in some cases, re-traumatizing. The implementation of CARE Court may perpetuate this stigmatization and lead to worse health outcomes for mental health consumers who need mental healthcare the most.

V. CARE Court presents a grave risk of inappropriate and unconstitutional applications.

Governor Newsom's "Fact Sheet: CARE Court," states: "[T]hose exiting a short-term involuntary hospital hold or after an arrest may be especially good candidates for CARE Court."[17] This assertion could not be further from the truth. Facilities can already keep patients on involuntary holds if they believe that a patient continues to meet the legal criteria to be a danger to themselves, others, or gravely disabled. Moreover, there are numerous sequential holds which allow facilities the ability to continue to legally hold individuals for longer durations, and said individuals also have an already existing constitutional remedy to challenge their hold. We understand one of the primary reasons that patients may be exiting a short-term involuntary hospital hold or arrest is because probable cause was not presently found during their certification review hearing. Despite certification review hearings being governed by a legal standard of probable cause, hearing officers often find people do not meet even this lenient standard. In many cases, hospitals fail to contact families to inquire about third party support. Hospitals also often fail to contact outside medical providers and/or fail to verify the credibility of a patient's explanation of the reason for their hospitalization. As such, the burden falls on the advocate at the certification review hearing to discover this information and to bring it before the hearing officer, who then finds no probable cause and discharges the patient's hold.

The writers submitting this letter to the Court have represented clients in cases where they have been placed on involuntary holds by the police for traffic violations, where medical providers have relied on complete fabrications from family members, and all too commonly, where clients are victims of domestic violence. Since CARE Court allows for a court-ordered response to be initiated by family, county and community-based social services, behavioral health providers, or first responders, the State fails to consider just how its own framework can be abused.

We have seen many instances of medical providers and families deeply upset at hearing officers' findings of no probable cause, even going so far as to complain to advocates' and hearing officers' supervisors, in the hopes of reversing a ruling. Should this Court agree to uphold CARE Court, the State risks giving said individuals a remedy that is tantamount to skirting issue preclusion. A

[17] *See* https://www.gov.ca.gov/wp-content/uploads/2022/03/Fact-Sheet_-CARE-Court-1.pdf

patient, whose status as gravely disabled, a danger to themselves, or a danger to others has already been adjudicated, will now be once again dragged before a court and forced to submit to a care plan for up to 24 months. As such, the aggregation of inappropriate applications and unconstitutionality of CARE Court's ramifications greatly outweigh the potential for good in its existing framework.

VI. CARE Court is not the appropriate remedy.

We face an ever-burgeoning unhoused, mental health, and substance abuse crisis in California. That is not in dispute and, as advocates, we implore the State of California to remedy and appropriately serve these disenfranchised groups. CARE Court, however, is not the appropriate solution. It will compound these problems. When advocates meet with patients, many are not even aware of their diagnosis or their medications. This is not because they are unable to understand or remember, but because they were never told. Many report that they were never offered the opportunity to be at the hospital voluntarily, either at the time of admission or during the course of their stay, even if they willingly and voluntarily came to the hospital. This is all despite the fact that voluntary treatment is preferred under the law and that this preference is codified under Welfare and Institutions Code §5150(c) and §5250(c).

Patients are thrust into a hostile and paternalistic healthcare system, which puts them at odds with their providers, and then, upon discharge, grants them little to no options for follow up outpatient care. Rather than adopting CARE Court, the State should prioritize funding for permanent housing, voluntary outpatient mental services, preventative health services, and other community-based mental health resources so all consumers can have access to culturally-competent care, especially those from historically excluded communities. Research shows that increasing funding of county mental services is associated with a decline in involuntary mental health holds.[18] Long-term stabilization from community mental health services could achieve the same cost savings and community benefits that counties seek to achieve with additional holds and coercive unconstitutional programs without undermining patient autonomy, dignity, due process rights, and equitable access to mental healthcare.

Involuntary mental health holds undermine the ability of consumers to have a voice in their mental health treatment process. CARE Court does nothing to guarantee that consumers will engage with their post-treatment plan. In our work in hospitals and communities, PRAs often hear from patients that after submitting to care—particularly patients that do so voluntarily and are still placed on

[18] Bruckner, Tim A., et al. "Involuntary civil commitments after the implementation of California's Mental Health Services Act." *Psychiatric Services* 61.10 (2010): 1006-1011.

holds—they are fearful of ever seeking out care again. Our mental healthcare and substance abuse addiction programs rely on fear, where patients are afraid to report symptoms to their providers, lest they be put on a hold. CARE Court exacerbates these concerns for consumers, who will now be forced to submit to lengthy care plans that do not respect their autonomy and that do not provide the necessary housing and other support services required to tackle California's mental healthcare crisis. In launching CARE Court, the State fails to consider how many consumers will refuse to seek any form of healthcare treatment as a result. Mental health professionals and the State should prioritize voluntary processes, community-based treatments, and other resources like benefits programs and housing, instead of placing patients into coercive and unconstitutional programs such as CARE Court.

VII. Conclusion

For these reasons, The Law Foundation of Silicon Valley and CAMHPRA respectfully urge this Court to compel Respondents to refrain from enforcing the CARE Act, and to set this matter for full briefing.

Respectfully submitted,

Melanie Roland (No. 303471)

Asha Albuquerque (No. 332901)
Rebecca Basson (No. 339646)
Sharla Tran (J.D. Advocate) for
THE LAW FOUNDATION OF SILICON VALLEY

Lisa Long (President) for
CALIFORNIA ASSOCIATION OF MENTAL HEALTH PATIENTS' RIGHTS ADVOCATES

PROOF OF SERVICE

I am over 18 years of age and not a party to this action. I am employed by the Law Foundation of Silicon Valley. My address is 4 North Second Street, Suite 1300, San Jose, CA 95113.

On February 17, 2023, I served:
1. Amicus Letter
on the interested parties as follows: VIA TrueFiling

GAVIN NEWSOM OFFICE OF GOVERNOR 1021 O Street, Suite 9000 Sacramento, CA 95814 in his official capacity as Governor of the State of California	OFFICE OF THE ATTORNEY GENERAL 1300 "I" Street Sacramento, CA 95814-2919CR
MARK GHALY JARED GOLDMAN California Health & Human Services Agency 1215 O Street Sacramento, CA 95814 in his official capacity as Secretary of the California Health and Human Services Agency	
MELINDA R. BIRD S. LYNN MARTINEZ SARAH J. GREGORY Attorneys for Petitioner Disability Rights California 350 S. Bixel Street, Suite 290 Los Angeles, CA 90017	MELINDA R. BIRD S. LYNN MARTINEZ SARAH J. GREGORY Attorneys for Petitioner Disability Rights California 1000 Broadway, Suite 395 Oakland, CA 94609

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on February 17, 2023 at San Jose, California.

Declarant, Melanie Roland