UC Law Constitutional Quarterly

Volume 51 | Number 4 | Article 5

Summer 2024

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Christina Strohmann, *“It’s Not Ok to Not Be Ok”: Suicide, California’s Lanterman-Petris-Short Act, and The Constitution*, 51 HASTINGS CONST. L.Q. 535 (2024).
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"It's Not Ok to Not Be Ok": Suicide, California's Lanterman-Petris-Short Act, and The Constitution

CHRISTINA STROHMANN*

Darkness is the absence of light. Happiness is the absence of pain.

\- Jess Bowen, Breaking Point

ABSTRACT

Individuals who commit suicide are not incompetent or even making an irrational decision. Yet state laws, such as the Lanterman-Petris-Short Act in California, continue to allow mental health professionals to lock up suicidal patients in psychiatric facilities against the patient's will. These commitments, however, are not always beneficial, and in many instances are detrimental to both the patient and the mental health professional. Patients can be traumatized from the experience, feel more suicidal from lack of hope and feelings of betrayal. Mental health professionals cannot effectively treat suicidal patients when providers are fearful of liability or when their patients refuse to share information because they think they will be committed. As mental health awareness increases, so does the awareness of involuntary commitments and the dangers of seeking help. Current mental health laws can deter suicidal individuals and others struggling with their mental health from getting any help at all, effectively nullifying the goal of the laws aimed to protect individuals from suicide. This note will analyze the Lanterman-Petris-Short Act and will suggest improvements that should be made to truly

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help achieve the goal of helping suicidal individuals without resorting to actions akin to imprisonment.

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I. INTRODUCTION

Over two centuries ago, the Founding Fathers wrote, "[w]e hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, *Liberty* and the pursuit of Happiness."[1] From a legal perspective, suicide is:

1. The right of self-determination;
2. The right of privacy;
3. The right to determine the quality of one's life;
4. The right to control one's own life and own body;
. . .
7. The right to determine one's own future;
. . .
9. Freedom of choice;
. . . and finally,
15. The right to die with dignity.[2]

The involuntary commitment of those who are suicidal or simply deemed suicidal violates the fundamental rights of liberty, self-determination, and substantive due process. While states have a compelling interest in preserving life, these interests must be weighed against an individual's fundamental rights; accordingly, any actions to nullify these rights must be narrowly tailored. In California, the Lanterman-Petris-Short Act ("LPS")[3] governs the commitment of suicidal people, and while the LPS has many commendable aspects and even serves as a model for other states, there are still constitutional issues that must be addressed.

Part II of this note will address the right to self-determination, the state's *parens patriae* power, and the trend of assuming that those who commit

1. THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776) (emphasis added).

2. SUSAN STEFAN, RATIONAL SUICIDE, IRRATIONAL LAWS: EXAMINING CURRENT APPROACHES TO SUICIDE IN POLICY AND LAW 67 (2016) (quoting John H. Hews, *Trial Court Decision in Bouvia I*, 1 ISSUES L. & MED. 485 (1986)).

3. Lanterman-Petris-Short Act, CAL. WELF. & INST. CODE §§ 5000–5579.

suicide are incompetent and mentally ill. Both assumptions have defined the psychiatric treatment of suicidal individuals by modern-day mental health professionals. Part III will discuss strict scrutiny and the different requirements for involuntary commitment laws as defined by Supreme Court precedent and California's LPS. Part IV will address the constitutional issues of the LPS as it relates to due process, fundamental rights of liberty and self-determination, and how it may or may not survive strict scrutiny within the judicial system. Part V will address some reasons for justifying civil commitments from medical and non-medical perspectives. Part VI will discuss recommendations for changes in the LPS by first arguing that suicidal people should be completely removed from the LPS until less restrictive options have been exhausted and scientific research allows more accurate identification of individuals in imminent danger of completing suicide. In the alternative, it will suggest changes to the LPS process of committing suicidal people if there can be no carveout.

This note will focus only on the civil involuntary inpatient commitment of suicidal adults in California who are not suicidal as a result of biologically impairing mental illnesses, such as schizophrenic or psychotic disorders. It will not focus on minors, gravely disabled individuals, medical ethics, assisted suicide, euthanasia, involuntary commitment of criminals, the right to die, involuntary outpatient commitment, the right to refuse treatment after an involuntary commitment, or other state laws regarding involuntary commitment. However, some concepts from these subjects will be briefly addressed when relevant to the civil involuntary commitment of suicidal people in California.

II. ERRONEOUS ASSUMPTIONS OF INCOMPETENCE AND MENTAL ILLNESS

Involuntary commitment of suicidal people deprives them of their fundamental rights to liberty and freedom to make their own decisions. Therefore, it is important to understand the state's justifications and their appropriateness when treating suicidal people differently. Unfortunately, many rationales are based on incorrect assumptions, and despite mounting evidence of this, these beliefs still dictate mental health law.

A. Self-Determination and Parens Patriae State Power

The right to self-determination is usually found in right-to-die cases while involuntary commitment cases focus more on the right to liberty.[4] The right to self-determination is not a topic of focus of this note; however, it is

4. STEFAN, *supra* note 2, at 96.

nevertheless fundamental in understanding the state's power to involuntarily commit suicidal individuals.

All fifty states have laws that permit the involuntary commitment of suicidal people to psychiatric hospitals.[5] These laws stem from the states' *parens patriae* power[6] which allows the state to substitute its own judgment for the individual's where the individual could otherwise be harmed.[7] The rationale behind such usurpations of self-determination is that the individual is unable "to understand the need for care and treatment in a hospital when without hospitalization, the individual . . . would be dangerous to self."[8] The state also assumes that its decision is one that the individual would have freely chosen if he or she could understand the danger, or, in other words, if the individual were "competent."[9] Thus, the state can only exert its *parens patriae* power if the individual is, as a result of mental illness, a danger to self, incompetent to make healthcare decisions to avoid that harm, and would benefit from hospitalization.[10]

When states exert their *parens patriae* power to involuntarily commit a suicidal person, the state violates the individual's fundamental right to self-determination[11] because the state presumptively assumes the individual lacks the competency to make his or her own healthcare decisions.[12] The state's

5. *See* Edward Beis, *State Involuntary Commitment Statutes*, 7 MENTAL DISABILITY L. REP. 358 (1983) for brief summaries of involuntary commitment laws in all states.

6. Late Corp. of the Church of Jesus Christ of Latter-Day Saints v. United States, 136 U.S. 1, 57 (1890) ("*parens patriae* is inherent in the supreme power of every state"); *see also* Carol A. B. Warren, *Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act*, 11 L. & SOC'Y REV. 629, 630 (1977).

7. BRUCE J. WINICK, CIVIL COMMITMENT 66 (2005) [hereinafter WINICK, CIVIL COMMITMENT].

8. *Id.* at 42.

9. *Id.* at 66.

10. *Id.* at 42–43. *See* discussion *infra* Parts IV.C and IV.E for analyses on mental illness, danger, and treatment.

11. *See* BRUCE J. WINICK, THERAPEUTIC JURISPRUDENCE APPLIED 170 (1997) [hereinafter WINICK, THERAPEUTIC JURISPRUDENCE APPLIED]. The Supreme Court has repeatedly held that the right to liberty, bodily autonomy, and self-determination is fundamental right of substantive due process. *See, e.g.*, Lawrence v. Texas, 539 U.S. 558, 578 (2003) (holding that the Due Process clause protects an individual's right to bodily autonomy for same-sex relations); Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 851, 857 (1992) (holding that "choices central to personal dignity and autonomy" are protected by the Due Process Clause"), *overruled on other grounds by Dobbs*, 142 S. Ct. 2228 (2022); Roe v. Wade, 410 U.S. 113, 153 (1973) (qualifying but still finding a woman's fundamental right of bodily autonomy to choose and abortion), *overruled on other grounds by Dobbs*, 142 S. Ct. 2228 (2022); Griswold v. Connecticut, 381 U.S. 479, 485 (1965) (finding a fundamental right to choose contraceptives in marriage).

12. The Supreme Court has also held that the Due Process Clause protects a fundamental right of self-determination in healthcare decisions. *See, e.g.*, Riggins v. Nevada, 504 U.S. 127, 135 (1992) (holding that forced medication is "impermissible absent a finding of overriding justification and a determination of medical appropriateness."); Cruzan, 497 U.S. at 279 (assuming that the Constitution protects a competent individual's right to refuse even life-saving treatment);

parens patriae power is only justifiable when an individual is truly incompetent because the incompetency nullifies the individual's ability to exercise autonomy and therefore the commitment of the individual does not violate the right to self-determination.[13]

B. Defining Competency in Suicidal Individuals

Once declared incompetent, a suicidal person can be involuntarily committed to a psychiatric hospital and stripped of bodily liberty, arguably a stronger right than self-determination.[14] As such, it is imperative to determine how competence should be defined and appropriately applied, rather than assume suicidal individuals are incompetent.[15]

Historically, suicidal individuals have not been viewed as incompetent.[16] On the contrary, suicidal individuals were considered fully responsible for their actions.[17] When England made suicide a felony in the fourteenth century, the suicide victim's land was subject to forfeiture.[18] In the eighteenth century, England removed the forfeiture requirement if a jury found that the victim was insane,[19] thus allowing the surviving family members to gain control of the land.[20] Because many juries knew the families, jurors would frequently strive to define the victim as insane to not deprive their friends and acquaintances of their property.[21] The repeated finding of insanity became so common that suicide was automatically viewed as a product of insanity.[22]

Unfortunately, the association of suicidal people and insanity carried over into the United States.[23] While property forfeiture was not an issue in

Washington v. Harper, 494 U.S. 210, 222–21 (1990) (competent patients have a "significant liberty interest" in refusing medications).

13. WINICK, CIVIL COMMITMENT, *supra* note 7, at 66.

14. *See* THE DECLARATION OF INDEPENDENCE para. 2 (U.S. 1776) (explicitly stating that individuals have a right to liberty).

15. *See* George J. Annas & Joan E. Densberger, *Competence to Refuse Medical Treatment: Autonomy vs. Paternalism*, 15 U. TOL. L. REV. 561, 561 (1984) ("competence and liberty are inextricably interwoven.").

16. STEFAN, *supra* note 2, at 2.

17. *Id.* at 13.

18. Stacy L. Mojica & Dan S. Murrell, *The Right to Choose—When Should Death Be in the Individual's Hands?*, 12 WHITTIER L. REV. 471, 472 (1991).

19. *Id.*

20. *Id.* at 473; STEFAN, *supra* note 2, at 14.

21. STEFAN, *supra* note 2, at 14. Even Thomas Jefferson noted that extremes that jurors would employ to declare a suicide victim as insane because "they have no other way of saving the forfeiture." Thomas Jefferson, *Plan Agreed Upon by the Committee of Revisors at Fredericksburg, 13 January 1777*, *in* 2 PAPERS OF THOMAS JEFFERSON, 325.

22. STEFAN, *supra* note 2, at 15.

23. *Id.*

the United States, as it violated the Constitution, suicide was still considered a common law crime for many years—further promulgating the false belief that suicidal people were insane.[24] Although suicide is no longer a crime in any of the fifty states, the assumption of incompetence continues to infiltrate the mental health community.[25]

The history of associating suicidal people with insanity raises the question of whether suicidal people are actually incompetent and how exactly competency should be defined in these circumstances. There is no legal test for competency of suicidal individuals.[26] Even though there are some tests for competency in general, the standards for applying them are not uniform.[27] When it comes to making healthcare decisions, California defines competence as "a person's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives."[28] Even this standard, however, is vague when applied to a suicidal individual for purposes of an involuntary commitment.[29] Many suicidal people know the ultimate consequence of their life-ending decision, and they can (and do) communicate their intention clearly. However, is the acknowledgment of death the only consideration a suicidal person needs to have to be considered incompetent? What does it mean to understand the "nature" of a decision? Vagueness allows for arbitrary and capricious labels of incompetency;[30] and such ambiguity violates a suicidal individual's right to substantive due process.[31] Because the consequences of being labeled as incompetent are so severely detrimental to a person's fundamental rights, a more precise definition is required.[32]

Regardless of how competency is currently tested or defined, studies have consistently shown that mental illness does not equate to incompetence. One of these is the MacArthur treatment competence study, one of the most

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24. Mojica & Murrell, *supra* note 18, at 482; STEFAN, *supra* note 2, at 17.

25. *Id.* at 17–19 (some states still treat attempted suicide as a common law crime); Mojica & Murrell, *supra* note 18, at 487.

26. STEFAN, *supra* note 2, at 11; BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT 349 (1997) [hereinafter WINICK, THE RIGHT TO REFUSE].

27. WINICK, THE RIGHT TO REFUSE, *supra* note 26, at 349.

28. CAL. PROB. CODE § 4609.

29. Annas & Densberger, *supra* note 15, at 562.

30. *Id.*

31. Statutes are vague and violate due process when they do not 1) "give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden by the statute," United States v. Harriss, 347 U.S. 612, 617 (1954), and 2) "set reasonably clear guidelines for [decision makers] in order to prevent 'arbitrary and discriminatory enforcement,' . . ." Smith v. Goguen, 415 U.S. 566, 573 (1974) (citation omitted). The fact that the LPS does not even require competency for involuntary commitments is discussed in *infra* Part IV.B.

32. Recommendations for defining competency are discussed in *infra* Part VI.A.1.a.

comprehensive studies on this matter.[33] Using methods that reflect common legal standards for competency, the study found that many mentally ill individuals scored higher in healthcare decision competency than those without mental illnesses.[34] The study concluded that decisionmakers should not assume that mentally ill individuals cannot make their own treatment decisions.[35] Even if suicidality is a product of mental illness, states cannot assume that suicidal individuals are incompetent and exercise their *parens patriae* control over all suicidal individuals. Further, in cases where suicide is not a product of mental illness, then competency is not even a consideration for involuntary commitments, which require mental illness and a resulting danger to self.[36]

C. Suicide and Mental Illness

Since exertion of *parens patriae* requires incompetency as a result of mental illness, suicidal people should not be subject to involuntary commitments if they are not mentally ill. While suicidal tendencies can be symptoms of various mental illnesses, there is no evidence to show that all suicidal individuals suffer from a mental illness.[37] The mental health profession has tried to understand suicidal individuals based on those who have already committed suicide.[38] The flaw with this methodology is that when a suicide victim's mental health is evaluated after they have committed the suicide, and the evaluator knows the individual died by suicide, there is a confirmation bias towards finding a mental illness that could have led to the suicide.[39] This logical fallacy leads psychiatrists to believe that those who are alive but suicidal most likely also suffer from a mental illness as well.

However, a Harvard study disproved the hypothesis that suicidality is automatically a result of a mental illness by asking two groups of physicians

33. WINICK, CIVIL COMMITMENT, *supra* note 7, at 104.

34. Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study. III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 L. & HUM. BEHAV. 149, 171 (1995).

35. *Id.*

36. *See* discussion *infra* Part II.C.

37. *See generally* Kara B. Fehling & Edward A. Selby, *Suicide in DSM-5: Current Evidence for the Proposed Suicide Behavior Disorder and Other Possible Improvements*, 11 FRONTIERS PSYCHIATRY, Feb. 4, 2021, at 1. THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS ("DSM-V") currently only includes suicidal thoughts or behaviors as symptoms of Major Depressive Disorder and Borderline Personality Disorder. While the DSM-V has proposed Suicidal Behavior Disorder to be accepted as an official mental disorder into the manual, it has not yet occurred. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 20 (5th ed. 2013) [hereinafter DSM-V].

38. *See* STEFAN, *supra* note 2, at 101.

39. *See id.*

to diagnose suicide victims based on the victim's history.[40] One group knew that the individuals had committed suicide, while the other group did not.[41] The first group diagnosed 90% of the victims with a mental illness.[42] On the other hand, the group that did not know about the suicide diagnosed only 22% of the victims with a mental illness.[43] The study's results highlight that many suicidal people may not have a mental illness, or at least not one diagnosable for the purposes of involuntary commitments. Until more concrete evidence shows that suicide is a mental illness or directly related to one, involuntary commitment laws should not be so quick to commit suicidal individuals.

The remainder of the note will assume that suicidal individuals are mentally ill for purposes of involuntary commitment unless otherwise stated, even though this assumption still does not justify laws like the LPS.

D. Psychiatrists and Suicidal Individuals

Despite the lack of evidence to show that suicidal individuals are automatically incompetent, states and mental health professionals continue to treat suicidal individuals differently from those not suffering from any alleged mental illness. When an individual is considered competent, courts almost uniformly uphold the patient's right to refuse treatment, even if the consequence is death, regardless of whether life-saving treatment is readily available or whether physicians agree with the patient's choice.[44] Competence is usually only questioned when a patient declines a physician's recommended treatment, as it tends to be with a suicidal individual who does not want to voluntarily check into a psychiatric facility.[45]

Since there is no clear guideline for defining competency, mental health professionals can substitute their own judgment for what is a competent decision, label the patient as lacking "insight," and claim that the patient's suicidality is a result of a mental illness. Since physicians will rarely, if ever, agree with a decision to commit suicide, suicidal individuals will almost always be labeled as incompetent due to a mental illness.[46]

The resistance from mental health professionals to respect suicidal decisions borders on the extreme, partly because psychiatrists are trained to treat mental illnesses. Since mental illness is so often assumed to be the root

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40. *Id.* at 102.

41. *Id.*

42. *Id.*

43. *Id.*

44. *See* STEFAN, *supra* note 2, at 35; Annas & Densberger, *supra* note 15, at 575 (citations omitted).

45. Annas & Densberger, *supra* note 15, at 573 (citation omitted).

46. STEFAN, *supra* note 2, at 31; Annas & Densberger, *supra* note 15, at 573.

of suicidal behavior, many psychiatrists refuse to believe that there is a competent and mentally healthy way to choose suicide.[47] Psychiatrists argue that suicidality is separately treatable from concurring physical illnesses,[48] even boldly stating "a patient who is terminally ill and attempts suicide may be competent to refuse life-saving treatment of the terminal illness, while simultaneously being incompetent to refuse treatment related to the suicide attempt."[49] While it is commendable for psychiatrists to want to treat individuals who are in so much pain that they want to end their life, suicidality should be treated without the coloration of a mental illness. Failure to do so invalidates the individual's suffering by saying there is something mentally wrong with him or her.

Misguided assumptions that suicidal individuals are incompetent, mentally ill, and only treatable in a psychiatric facility come at the cost of an individual's right to self-determination and bodily liberty. Because competency is a necessary element of the state's *parens patriae* power to commit a suicidal individual, better methods of determining competency must be developed, and suicidal individuals should not be involuntarily committed to psychiatric facilities in violation of their fundamental rights.

III. REQUIREMENTS AND PROCEDURES FOR INVOLUNTARY COMMITMENTS

The Supreme Court has held that involuntary commitments must be reviewed under strict scrutiny because they completely deprive the individual of their very basic and fundamental right to bodily liberty.[50] Therefore, the involuntary commitment of suicidal people must be narrowly tailored and the least restrictive option to further the state's goal of preserving the individual's life.[51] This requires clear definitions of terms, such as "mental illness" and "danger" to avoid over-inclusivity, and establishing that hospitalization can help reduce suicidality.

47. *See* STEFAN, *supra* note 2, at 31; Thomas S. Zaubler & Mark D. Sullivan, *Psychiatry and Physician-Assisted Suicide*, 19 CONSULTATION-LIAISON PSYCHIATRY 413, 413 (asserting that psychiatrists are "almost uniformly critical of the rationality of suicide.").

48. Zaubler & Sullivan, *supra* note 47, at 415.

49. STEFAN, *supra* note 2, at 37.

50. Foucha v. Louisiana, 504 U.S. 71, 80 (1992).

51. Washington v. Glucksberg, 521 U.S. 702, 728 (1997); Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 281 (1990).

A. The Supreme Court of the United States

The Supreme Court has held freedom from bodily restraint is a fundamental right,[52] and involuntary commitments that deprive a suicidal individual of this right is a "massive curtailment of liberty."[53] Laws that permit a complete deprivation of this fundamental right are therefore subject to strict scrutiny,[54] and must be narrowly tailored to achieve a compelling state interest.[55] However, the standard of proof required for involuntary commitments is set at "clear and convincing" rather than "beyond a reasonable doubt" even though both involuntary commitments and imprisonment involve very similar accosts on fundamental rights.[56] The Court justified this intermediate standard of proof by reasoning that involuntary commitments are not intended to be punitive as in criminal law and are instead meant to help the individual.[57]

In the 1970s, the Supreme Court required that involuntary commitments be reasonably related to the purpose of the commitment[58] and that people with mental illnesses who are capable of living safely in freedom on their own, or with the help of their community, could not be involuntarily committed.[59] The Court added in *Foucha v. Louisiana* that the individual who is dangerous but not mentally ill cannot be committed, which some have interpreted as a danger must be a result of the mental illness.[60] In other words, a dangerous but mentally healthy individual could not be committed.[61]

52. *Foucha*, 504 U.S. at 80 (involving an insane acquitee diagnosed with antisocial personality disorder, considered a danger to others, under indefinite commitment).

53. Vitek v. Jones, 445 U.S. 480, 491 (1980) ("We have recognized that for the *ordinary citizen*, commitment to a mental hospital produces 'a massive curtailment of liberty . . .'") (emphasis added) (citation omitted).

54. *See* Shelton v. Tucker, 364 U.S. 479, 488 (1960); *see also Foucha*, 504 U.S. at 86 (implying involuntary commitment laws require strict scrutiny by requiring the state to have a "particularly convincing reason" to involuntarily commit individuals who were dangerous but not mentally ill); United States v. Salerno, 481 U.S. 739, 750 (1987) (involving a limited pretrial detention of an individual accused of violent crimes and implying strict scrutiny by finding the statute did not violate due process as it applied to very narrow cases with a legitimate state interest).

55. The Supreme Court has held that states have a legitimate interest in preserving life and preventing suicide. *Glucksberg*, 521 U.S. at 728–29.

56. Addington v. Texas, 441 U.S. 418, 428 (1979) (involving indefinite involuntary commitment of an individual labeled as a danger to others).

57. *Id.* at 428. The court also noted that an error in civil commitment is not as severe as convicting an innocent person because observations of the patient will allow for corrections. *Id.* at 429.

58. Jackson v. Indiana, 406 U.S. 715, 738 (1972) (involving indefinite commitment of a criminal initially found incompetent to stand trial).

59. O'Connor v. Donaldson, 422 U.S. 563, 576 (1975) (involving indefinite commitment of a mentally ill individual who could live safely in the community with social help).

60. *Foucha*, 504 U.S. at 86.

61. STEFAN, *supra* note 2, at 99.

Coupling the *Foucha* Court's holding with its earlier requirement that the commitment bears some relationship to the purpose, an additional requirement of "therapeutic appropriateness" appears.[62] Therefore, the individual's mental illness must also be treatable, though not necessarily curable, in the psychiatric hospital to warrant involuntary commitment.[63]

Taken together, the Supreme Court seems to provide four requirements for involuntary commitments of suicidal individuals to prevent a suicide: 1) the suicidal individual must be mentally ill; 2) the suicidal individual must be a danger to self as a result of the mental illness; 3) involuntary hospitalization can treat the individual's suicidality (therapeutic appropriateness); and 4) the individual's suicidality cannot be effectively treated outside of the hospital (least restrictive alternative).[64]

B. California: Lanterman-Petris-Short Act

California adopted the LPS in 1972 with the goals of limiting indefinite involuntary commitments and providing treatment in the least restrictive environment.[65] The LPS has been commended for leading the movement towards increased rights for those with mental illnesses, and many states are modeling their laws after the LPS.[66] Importantly, the LPS has different laws that govern the state's interest to protect society from dangerous individuals and those that govern the state's interest to protect suicidal individuals from themselves.[67]

Under the LPS, a suicidal person may be held in a psychiatric facility for no more than a total of thirty-one days, composing of an initial 72-hour hold (Section 5150 hold)[68] and followed by two separate 14-day extensions (Section 5250 hold and Section 5260 hold).[69] Suicidal people can be initially held for seventy-two hours if an appropriate person, such as a psychiatrist, deems the individual "as a result of a mental health disorder, [] a danger to others, or to themselves, or gravely disabled."[70] Only "probable cause" is needed to hold the individual under LPS Section 5150, and at this stage,

62. WINICK, THERAPEUTIC JURISPRUDENCE APPLIED, *supra* note 11, at 111, 115.

63. *Id.* at 116.

64. *See* STEFAN, *supra* note 2, at 121.

65. CAL. WELF. & INST. CODE § 5001.

66. *See* Mark A. Hart, *Civil Commitment of the Mentally Ill in California: The Lanterman-Petris-Short Act*, 7 LOY. L.A. L. REV. 93, 134 (1974); Warren, *supra* note 6, at 630.

67. *See* Grant H. Morris, *Defining Dangerousness: Risking a Dangerous Definition*, 10 J. CONTEMP. LEGAL ISSUES 61, 75–76 (1999) (noting the American Psychiatric Association has even suggested danger to self to be conflated with grave disability or inability to provide for one's basic needs).

68. CAL. WELF. & INST. CODE § 5150.

69. *Id.* § 5250, 5260.

70. *Id.* § 5150. *See generally id.* §§ 5150–5155.

"probable cause" does not consider imminent danger.[71] The psychiatric facility must also evaluate the "appropriateness of the involuntary detention."[72] Once detained on a Section 5150 hold, the individual can only be released before the full seventy-two hours if a psychiatrist believes the individual no longer needs to be involuntarily detained.[73] No certification or review is needed as is required with further detention of a suicidal individual.

However, if the psychiatrist believes that the individual is "as a result of a mental health disorder. . . a danger to others, or to himself or herself, or gravely disabled," the psychiatrist may sign a certification to keep the individual for another fourteen days of "intensive treatment" on a Section 5250 hold.[74] A certification review hearing must be held within four days of the certification date to determine whether there is "probable cause" to continue the involuntary commitment.[75]

After these seventeen days, further involuntary hospitalization of the individual is then dependent upon whether the individual is a danger to others, danger to self, or gravely disabled. Article 4.5 of the LPS governs additional confinement specifically for suicidal people, as evidenced by the title "Additional Intensive Treatment of Suicidal Persons." A psychiatrist may sign a second certification to keep a suicidal individual for an additional fourteen days if the individual,

> "as a result of mental disorder . . . during the 14-day period or the 72-hour evaluation period, threatened or attempted to take his or her own life or who was detained for evaluation and treatment because he or she threatened or attempted to take his or her own life and who continues to present an imminent threat of taking his or her own life."[76]

However, no finding of "probable cause" or even a certification review hearing is required.

To summarize, the LPS requires 1) a mental illness and 2) danger as a result of that illness to involuntarily commit suicidal individuals for up to thirty-one days.[77] However, it does not require a finding from a psychiatrist that involuntary hospitalization would be appropriate after the initial

71. *Id.* § 5150.05, 5150(b).

72. *Id.* § 5151.

73. *Id.* § 5152.

74. *Id.* §§ 5250, 5252. *See generally id.* §§ 5250–5259.3.

75. *Id.* § 5256(a).

76. *Id.* § 5260. *See generally id.* §§ 5260–5268.

77. *See LPS Holds Chart*, LA COURT, https://www.lacourt.org/division/mentalhealth/pdf/lps-holds-chart.pdf (last visited Nov. 28, 2023) for a succinct table listing requirements for various LPS holds.

seventy-two hours,[78] nor does it require a finding no other less restrictive treatments outside the hospital would be effective.[79]

IV. CONSTITUTIONAL RIGHTS AND THE LANTERMAN-PETRIS-SHORT ACT

While most of the Supreme Court cases previously addressed involved indefinite commitments and the LPS has a very limited commitment duration for suicidal patients, the holdings are still applicable to subjects of the LPS—particularly after the initial 72-hour hold.[80] Since the LPS deprives suicidal individuals of the right to liberty, the LPS is subject to strict scrutiny and must be narrowly tailored to achieve California's compelling interest in preserving life. The lowered standard of proof, no requirement of incompetency, and vague parameters for defining mental illness and danger render the LPS overinclusive and therefore not narrowly tailored.[81] Further, it is doubtful that the LPS actually achieves the state's goal of preventing suicide. On the contrary, it may even increase suicide risks as well as cause many other harms to patients, providers, and others suffering from suicidality and mental illnesses. The LPS thus violates not only the Constitution's Due Process Clause[82] but also the Supremacy Clause[83] as California enforces state laws in direct conflict with federal laws set by the Supreme Court.

78. The LPS does require the psychiatric facility be "equipped and staffed to provide treatment," but this is very different from determining whether the treatment will be effective or even necessary. CAL. WELF. & INST. CODE § 5260(c).

79. *Contra id.* § 5250(d) (requiring finding that a gravely disabled person cannot survive safely without the involuntary commitment).

80. *See* cases cited *supra* notes 54–61; STEFAN, *supra* note 2, at 121 (conceding that a three-day hold may be helpful and necessary but anything after that should meet a narrow set of criteria).

81. Warren, *supra* note 6, at 631 ("The language of LPS is sufficiently general to allow psychiatric and judicial personnel to justify whatever balance they choose between the rights of the individual and the protection of society.").

82. The Fourteenth Amendment's Due Process Clause applies to states and does not permit them violate their constituents' fundamental rights without due process. U.S. CONST. amend. XIV, § 1 ("No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; *nor shall any State deprive any person of life, liberty, or property, without due process of law*") (emphasis added).

83. The Supremacy Clause states that federal laws made pursuant to the Constitution trump any conflicting state laws. U.S. CONST. art. VI, cl. 2 ("This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or *Laws of any State to the Contrary notwithstanding*.") (emphasis added).

A. Due Process: Lower and Absent Standard of Proof

"When the individuals involved are not criminals, but those who have been declared 'mentally ill,' the cry for due process suddenly grows faint."[84] Even though both imprisonment and involuntary commitments completely deprive people of their right to bodily liberty, the Supreme Court has only required a "clear and convincing" standard for involuntary commitments.[85] The Court was concerned that requiring any higher standard would obstruct medical care because psychiatrists would rarely be able to show an individual was imminently at threat of suicide "beyond a reasonable doubt."[86] Yet, this is precisely what should happen when the alternative is complete deprivation of a fundamental right, regardless of the duration.[87]

In California, some crimes are penalized with a maximum sentence of six months, a fine, or both.[88] Yet even these misdemeanors still require proof "beyond a reasonable doubt."[89] A survey of the time served for smaller crimes, such as drug possession,[90] show that the average time served was two months while the median was zero months, meaning more than half of those convicted of drug possession beyond a reasonable doubt had no deprivation of personal liberty.[91] Surprisingly, monetary fines for committed crimes require a standard of proof higher than the standard of proof required to deprive a suicidal individual of bodily liberty. Presumably, the reasoning is because convictions, even without prison time, can continue to negatively impact individuals; yet the same is true of involuntary commitments and the social stigmas that will continue long after patients are released.[92] Therefore, the current standard of proof requirement is severely inadequate for those facing involuntary commitment.

Some may argue that psychiatric hospitals have better conditions than prisons, but this is not always the case. Psychiatric patients have rights including wearing their own clothes, keeping personal possessions such as

84. Hart, *supra* note 66, at 94.

85. *Id.* at 104–06; *Addington*, 441 U.S. at 428.

86. *Addington*, 441 U.S. at 432.

87. Morris, *supra* note 67, at 83–84.

88. *See, e.g.*, CAL. PENAL CODE §§ 241 (assault), 243 (battery).

89. *Criminal and Misdemeanor*, SUPER. CT. CAL.: CNTY. NEV., https://www.nevada.courts.ca.gov/divisions/criminal-misdemeanor#:~:text=In%20all%20criminal%20cases%2C%20the,guilty%20beyond%20a%20reasonable%20doubt (last visited Nov. 29, 2023).

90. California Uniform Controlled Substances Act, CAL. HEALTH & SAFETY CODE § 11350 (penalties for drug possession involve a maximum imprisonment of one year, a fine, or both).

91. U.S. SENTENCING COMM'N, STATISTICAL INFORMATION PACKET: STATE OF CALIFORNIA 11 tbl.7 (2022), https://www.ussc.gov/sites/default/files/pdf/research-and-publications/federal-sentencing-statistics/state-district-circuit/2022/ca22.pdf.

92. *See Addington*, 441 U.S. at 426.

toiletries, and seeing daily visitors.[93] Yet, these rights can easily be revoked simply for "good cause," not even "probable cause," and no hearing or notice is required to do so.[94] On the other hand, prisoners are at least entitled to a hearing before similar rights are revoked.[95] A study on how involuntarily committed psychiatric patients and prisoners are treated highlighted even more discrepancies.[96] When patients contest their commitments before a court, 90% would lose, whereas criminals are convicted only 59% to 84% of the time at trial.[97] This is in part due to judges simply siding with psychiatrists whenever they claim a patient is incompetent.[98] Whereas fresh air is considered "critical to the well-being of prisoners and may be a civil right," psychiatric patients need to be granted this privilege based on behavior.[99] The study also showed that many patients complained of boredom, as they frequently do not have access to activities that prisoners do, such as "productive work, libraries, hobbies, or computers and email."[100] This shows that involuntary commitments can be more restrictive than prisons. The rationale for a higher standard of proof in criminal proceedings is that imprisonment takes away the individual's liberty, harms reputation, and has more severe consequences than an average civil case.[101] However, while psychiatric patients face the exact same issue with involuntary commitments, sometimes with more severe consequences, they are subjected to a substantially lowered standard of proof before their rights are disturbed. Therefore, "beyond a reasonable doubt" should be the standard for involuntary commitments of suicidal people. While it may lead to fewer commitments, there is no evidence that the enhanced standards will impair treatment, and it instead may spur progress toward helping to narrow the application of involuntary commitment laws.[102]

93. CAL. WELF. & INST. CODE § 5325.

94. *Id.* § 5326; Hart, *supra* note 66, at 103.

95. CAL. CODE REGS. tit. 15, §§ 3314–3315

96. *Mentally Ill and Locked Up: Prisons Versus Inpatient Wards for Psychiatric Patients*, PSYCHCENTRAL (Apr. 1, 2015), https://psychcentral.com/pro/mentally-ill-and-locked-up-prisons-versus-inpatient-wards-for-psychiatric-patients#7.

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

101. *Why Is the Burden of Proof Higher in Criminal Cases?*, WHITE LAW PLLC, https://www.whitelawpllc.com/faqs/why-is-the-burden-of-proof-higher-in-criminal-cases/ (last visited Nov. 29, 2023).

102. Hart, *supra* note 66, at 134 (noting criticism that the LPS's more stringent standards for involuntary commitment could impede treatment was unfounded as studies show the LPS did not negatively affect therapy).

When it comes to the LPS, the standard is even lower than "clear and convincing." All that is needed is "probable cause" or a "simple finding" of danger to self for the initial 72-hour detention and first 14-day commitment.[103] "Probable cause" is much lower than "clear and convincing."[104] No hearing is required for a second 14-day hold, which nullifies the standard of proof altogether. So, the longer the hospital deprives suicidal individuals of their liberty, the less evidence it needs to prove to keep them for longer. It is easier to deprive a suicidal individual of liberty for thirty-one days than it is to fine criminals $1000 for their crime. Not only does the LPS deprive suicidal individuals of their rights that would otherwise require proof "beyond a reasonable doubt" to do, but it also flies in the face of the Supreme Court's established standard of proof in *Addington v. Texas* of "clear and convincing" evidence in involuntary commitment cases.[105] In fact, the LPS even runs counter to California's own precedent involving involuntary commitments.[106] In *Conservatorship of Roulet*, the California Supreme Court acknowledged the similarities between loss of liberty in psychiatric institutions and prisons and even stated that wrongfully committing individuals is just as egregious as convicting an innocent man.[107] Thus, civil commitments should have the same due process protections as criminal proceedings.[108] The "beyond reasonable doubt" standard was whittled away, allowing the LPS to violate suicidal patients' substantive due process rights without legal recourse.[109]

B. Right to Self-Determination: Failure to Require Incompetency

The LPS does not require a finding of incompetency from a mental disorder to commit suicidal individuals.[110] The LPS use the definition of "mental disorders,"[111] as the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-V"), which does not include

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103. Morris, *supra* note 67, at 84; *see* discussion *supra* Part III.B.

104. Richard Seltzer et al., *Legal Standards by the Numbers: Quantifying Burdens of Proof or a Search for Fool's Gold?*, 100 JUDICATURE 56, 61 (2016).

105. *Addington*, 441 U.S. at 428.

106. Conservatorship of Roulet, 590 P.2d 1 (Cal. 1979).

107. *Id.* at 4.

108. *Id.* at 11.

109. *See generally* Paul Bernstein, *Eroding* Roulet*: How the Courts Ignore a Landmark in California Civil*

Commitment Hearings, 33 U.S.F. L. REV. 59 (1998).

110. *Contra* CAL. WELF. & INST. CODE § 5008(h) (requiring incompetency to commit gravely disabled individuals that involves conditions either "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" or "in which a person, has been found mentally incompetent under Section 1370 of the Penal Code.").

111. *See* Conservatorship of Chambers, 139 Cal. Rptr. 357, 361 n.5 (Cal. Ct. App. 1977).

a competency component.[112] The LPS only requires a psychiatrist's finding that the individual is a danger to self as a result of a mental illness.[113] Perhaps this is because of the strong historic assumptions that decisions to commit suicide equate to incompetence, or maybe it is because the LPS has shorter incremental commitments. Regardless of the reason, involuntary commitment of suicidal individuals under the LPS is an exercise of California's *parens patriae* power, which cannot be used to disregard an individual's freedom to self-determination without a finding of incompetency.[114] While requirements of incompetency do not always protect suicidal individuals from involuntary commitments, not requiring this at all is an even more egregious violation of due process.[115]

C. Strict Scrutiny and Overinclusivity: Vague Definitions of "Mental Disorder" and "Danger"

Since "danger" arising from a "mental disorder" is required to involuntarily commit a suicidal person under the LPS, there should be clear definitions of these terms for their specific application.[116] The LPS does not define either term with enough clarity, allowing decisionmakers to exercise capricious judgment to deprive individuals of bodily liberty and self-determination.[117] Not only does this make the LPS overinclusive, but it can also create the issue of making psychiatrists "unimpeachable witnesses."[118]

1. Defining "Mental Disorder" for Involuntary Commitments of Suicidal Individuals

When the Supreme Court addressed the issue of defining "mental illness" for the purpose of involuntarily committing convicted criminals, the Court noted several important points that serve as guidelines for states

112. "A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning." DSM-V, *supra* note 37. A "significant disturbance in an individual's cognition" is not the same as incompetency. *Id*.

113. *See* discussion *supra* Part III.B.

114. *See* discussion *supra* Part II.A.

115. *See* WINICK, CIVIL COMMITMENT, *supra* note 7, at 109 (stating that commitment laws that do not also require incompetency should be unconstitutional).

116. When defining mental illness, "we should really ask a further question: 'Mentally ill for what purpose?' Mental illness . . . is not something that has an independent essence; different contexts may call for different judgments." ELYN R. SAKS, REFUSING CARE 33 (2002). Failure to carefully define statutes violate due process under the void-for-vagueness doctrine. *See* cases cited *supra* note 31.

117. Morris, *supra* note 67, at 66; Warren, *supra* note 6, at 631; *see also* SAKS, *supra* note 116, at 22; WINICK, THERAPEUTIC JURISPRUDENCE APPLIED, *supra* note 11, at 122.

118. Hart, *supra* note 66, at 125.

defining "mental disorders" for the purposes of involuntary commitment. First, the definition should be tailored to the purpose of applying the term.[119] Second, the definition must be legal not medical.[120] Third, psychiatry is only to guide, not define, legal standards for defining mental disorders because not only is psychiatry an "imprecise and developing science," but its goals are not the same as the law's.[121] The Supreme Court offered a guiding definition of "mental disorder" that factored in constitutional rights and determined the definition to be a "special and serious lack of ability to control [dangerous] behavior."[122]

The LPS uses the DSM-V's definition of "mental disorders," which is a medical definition, not a legal standard. The DSM-V, too, acknowledges this.[123] Without tailoring the definition of mental disorders to involuntary commitments, or even involuntary commitments of suicidal people specifically, the LPS risks being overinclusive,[124] allowing psychiatrists to commit suicidal individuals who do not meet the Supreme Court's rule of serious lack of control.[125] This is further exacerbated by the fact that even psychiatrists do not agree on how to apply criteria from DSM-V to diagnose mental disorders.[126] The DSM-V's definition is used to diagnose mental illnesses, but the LPS is using the definition to deprive individuals of bodily liberty. Whether the LPS uses the *Crane* rule or a modification,[127] the LPS should

119. *See* Kansas v. Hendricks, 521 U.S. 346, 358 (1997). "Not all 'conditions' thought to be mental illnesses or disorders for certain purposes will suffice . . . when the purpose is commitment to a psychiatric hospital." WINICK, THERAPEUTIC JURISPRUDENCE APPLIED, *supra* note 11, at 133.

120. *Hendricks*, 521 U.S. at 359; WINICK, THERAPEUTIC JURISPRUDENCE APPLIED, *supra* note 11, at 125.

121. Kansas v. Crane, 534 U.S. 407, 413 (2002).

122. *Id.* at 413.

123. "When DSM-5 categories, criteria, and textual descrip-tions are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis." DSM-V, *supra* note 37, at 25.

124. "[B]ecause of the unavoidably ambiguous generalities in which the American Psychiatric Association describes its diagnostic categories, the diagnostician has the ability to shoehorn into the mentally diseased class almost any person he wishes, for whatever reason, to put there." Joseph M. Livermore et al., *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75, 80 (1968).

125. *See* STEFAN, *supra* note 2, at 101.

126. Meredith Lenell, *The Lanterman-Petris-Short Act: A Review after Ten Years*, 7 GOLDEN GATE U. L. REV. 733, 738 (1977).

127. Since *Crane* and *Hendricks* both involved criminals, the standard proposed may not be appropriately tailored to LPS commitments of suicidal individuals. The *Crane* Court even noted that it was providing guidelines based on "specific circumstances" and that states still have the freedom in defining mental disorders for involuntary commitments. *Crane*, 534 U.S. at 413–14.

still define "mental disorders" in a way that captures the individuals it targets.[128]

2. Predicting Danger in Suicidal Individuals

The most problematic element for involuntarily commitment of suicidal individuals is predicting whether the individual will actually commit suicide.[129] While the LPS does not define danger but does require "imminent" danger to self for involuntary commitment of suicidal individuals,[130] California courts have consistently held that danger in suicidal individuals is limited to suicidal talk, behaviors, and actions.[131] Thus, the LPS's definition of danger is not lacking in defining the behavior itself, but rather in defining the degree and probability of the danger to self.[132] This allows the LPS to commit individuals who were never legitimately at risk of killing themselves, and therefore result in overinclusive and unconstitutional actions when the result is a complete deprivation of liberty.[133]

The state may have a compelling interest in preserving life by preventing suicide, but it certainly does not have a compelling interest in preventing people from talking or even thinking about suicide. Committing people who have suicidal ideation, or who even threaten to kill themselves, would indisputably be unconstitutional if the state knew that these behaviors would not lead to suicide.[134] Likewise, it would also be unconstitutional for the state to commit someone who never gave any indication of suicidal tendencies but who would commit suicide (perhaps the state had a crystal ball).[135] The question then becomes: how can the state accurately spot individuals who would kill themselves, regardless of whether they had given any prior indications? The simple answer—it cannot. There is a plethora of scholarship addressing this issue that have all found there is no way to precisely predict

128. Regardless of how this is defined, there is still doubt as to whether suicidal people are mentally ill at all. *See* discussion *supra* Part II.C.

129. *See* STEFAN, *supra* note 2, at 109; Hart, *supra* note 66, at 113.

130. CAL. WELF. & INST. CODE § 5260(a).

131. Warren, *supra* note 6, at 629.

132. The Supreme Court has not laid a foundation for defining the level of harm and probability of that harm occurring for defining "danger" in involuntary commitment laws. Morris, *supra* note 67, at 65.

133. *See* Robinson v. California, 370 U.S. 660, 666 (1962); *accord* Cross v. Harris, 418 F.2d 1095, 1101–02 (D.C. Cir. 1969) (involuntary commitment for "a mere propensity is punishment not for acts, but for status, and punishment for status is hardly favored in our society.").

134. *See* STEFAN, *supra* note 2, at 96 (talking about suicide, threatening suicide and suicidal ideation alone are unconstitutional grounds for involuntary commitments because there is no reliable way to correlate these with actual suicide).

135. *Id.* at 108 (positing that many people who are truly suicidal hide it very well, even from those closest to them).

whether an individual that presents with LPS-defined suicidal behavior will ultimately commit suicide.[136]

The mental health profession has developed multiple risk factor screening tests, but to date, there is still not a uniform test that the profession can agree on.[137] None of the tests have been able to accurately identify what risk factors contribute to suicide,[138] and all of them fall short of the "clear and convincing" standard needed for involuntary commitments.[139] At best, some studies can find correlations between certain variables and dangerous behavior, but cannot establish causation; any increase in danger caused by mental illness is negligible against the weight of complete deprivation of liberty.[140]

A CDC study showed that 37,500 out of 8,300,000 million people who seriously considered suicide actually committed suicide every year.[141] That same year, approximately 2,200,000 made plans, and 1,000,000 attempted suicide.[142] In other words, only 0.45% of those who seriously contemplated suicide followed through with the act, 1.70% of those who made plans committed suicide, and 37.5% of attempted suicides were successful. All these individuals at every stage of suicidal behavior would have met the threshold for involuntary commitment under the LPS. In these data, the LPS could have unconstitutionally applied to 99.55% of individuals with serious thoughts of suicide, 98.3% of individuals who made plans, and 62.5% of individuals who attempted suicide. This shows that serious thoughts of suicide, and even plans to commit suicide, are only tenuously related to the danger of death by suicide.[143] Even attempts cannot confidently predict whether someone will die by suicide.[144] Yet, risk assessment scales continue to rely on these factors to determine suicidality and involuntary

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136. *E.g.*, BRUCE A. ARRIGO, PUNISHING THE MENTALLY ILL: A CRITICAL ANALYSIS OF LAW AND PSYCHIATRY 88 (2002); SAKS, *supra* note 116, at 50; STEFAN, *supra* note 2, at 109; Morris, *supra* note 67, at 85.

137. Linda Ronquillo et al., *Literature-Based Recommendations for Suicide Assessment in the Emergency Department: A Review*, 43 J. EMERG. MED. 836, 838 (2012).

138. *Id.* at 837; *see also* STEFAN, *supra* note 2, at 111.

139. STEFAN, *supra* note 2, at 109.

140. Morris, *supra* note 67, at 89–90, 94.

141. Alex E. Crosby et al., *Suicidal Thoughts and Behaviors Among Adults Aged ≥18 Years – United States, 2008–2009*, 60 MORBIDITY & MORTALITY WKLY. REP. SURVEILLANCE SUMMARIES, Oct. 21, 2011, at 1–2.

142. *Id.*

143. In fact, planning suicide may even show competency under California's definition since planning indicates some level of "mak[ing] and communicat[ing] a decision." *See* CAL. PROB. CODE § 4609.

144. STEFAN, *supra* note 2, at 109. Some may contend that failed attempts are not from a lack of imminent danger to self. Even if this is true, there are other issues with involuntarily committing those who have attempted suicide as many times involuntary commitments can increase suicidality, which would be particularly problematic for those who had already made very serious attempts.

commitments.[145] Given the unreliability of the screening factors, there is even more reason to remove suicidal individuals from being subjected to involuntary commitment laws such as the LPS, at least until there are improved methods to prove a very critical "danger" element required for complete deprivation of bodily liberty.[146]

D. Due Process: The "Unimpeachable" Psychiatrist

If both the legal and medical professions acknowledge that the danger of suicide cannot be predicted and mental disorders are poorly defined for involuntary commitment purposes, how is it that suicidal people continue to be deprived of liberty and due process?[147] Part of the reason lies with courts overly relying on psychiatrists' personal, not evidentiary, opinion of whether a suicidal individual is in imminent danger of taking his or her life.[148] Few would dispute these practices to be *unethical*, but the question is whether or not these are *legal*.[149] Unfortunately, the answer, set by the Supreme Court, is "yes." Courts are eager to have an "objective" reason for depriving suicidal individuals of liberty, and in doing so, they are willing to accept even unethical "expert" testimony.[150] Even though the Supreme Court admits that psychiatric testimony is unreliable,[151] it can still be admitted.[152] No

145. *See, e.g.*, *A Simple Set of 6 Questions to Screen for Suicide*, COLUM. UNIV. DEP'T PSYCHIATRY (Sept. 30, 2021), https://www.columbiapsychiatry.org/news/simple-set-6-questions-screen-suicide. The Columbia Suicide Severity Risk Scale (C-SSRS) is one of the more common suicide risk assessment tools. It asks six questions that focus on suicidal thoughts and planning, two factors shown to have very little correlation with the act of committing suicide.

146. Morris, *supra* note 67, at 85.

147. Hart, *supra* note 66, at 14 (vague definitions allow psychiatrists to use personal feelings to commit individuals); Livermore et al., *supra* note 124, at 80 (poor parameters allow psychiatrists to "shoehorn into the mentally diseased class almost any person he wishes, for whatever reason").

148. STEFAN, *supra* note 2, at 112; *see also* ARRIGO, *supra* note 136, at 86. This power allows psychiatrists to basically assume the role of "functionaries of social order." *Id*. at 78.

149. STEFAN, *supra* note 2, at 113; Morris, *supra* note 67, at 86 ("Clinical predictions of future dangerousness are *so deficient* that Stone and others question whether mental health professionals act ethically when they make them.") (emphasis added) (citation omitted). Even the American Psychiatric Association contends that reliance of unreliable psychiatric predictions is unethical. Brief for the American Psychiatric Association as Amici Curiae Supporting Petitioner, Barefoot v. Estelle, 460 U.S. 1067 (1983) (No. 82-6080); *see also* Hart, *supra* note 66, at 114 (courts rely on psychiatrists who are "speaking a different language" than is needed for legal determinations).

150. STEFAN, *supra* note 2, at 113.

151. *Crane*, 534 U.S. at 408 ("[P]sychiatry . . . is an ever-advancing science"); *Addington*, 441 U.S. at 430 ("Psychiatric diagnosis, in contrast, is to a large extent based on medical 'impressions' drawn from *subjective analysis* and filtered through the experience of the diagnostician. This process often makes it *very difficult for the expert physician to offer definite conclusions* about any particular patient.") (emphasis added); *see also O'Connor*, 422 U.S. at 575 (implying that a psychiatric determination cannot be "given a reasonably precise content" or "identified with reasonable accuracy").

152. *Barefoot*, 463 U.S. at 897.

evidentiary basis,[153] or even scientific standard,[154] is required for psychiatrists to assert that a suicidal individual is dangerous enough to need hospitalization. Training and personal observations from experience will suffice.[155] The *Daubert* test necessary to decide admission of expert testimony is tossed to the wayside.[156]

Arbitrary psychiatrist predictions lead to a problem that Mark Hart described as the "unimpeachable witness."[157] Neither attorneys nor judges care to question a psychiatrist's determination that a suicidal individual is dangerous and in need of commitment, which allows the psychiatrist to answer simple "yes" or "no" questions to determine the individual's fate.[158] Studies show that the extent of deference to psychiatrists is so extreme that most civil commitment hearings only last around five minutes before the individual is locked away.[159] This phenomenon has led to an egregious lack of adversarial hearings required for substantive due process.[160]

Even though California, through application, has a strict standard for defining danger, the LPS still provides no safeguards against psychiatrists capriciously labeling individuals to fit those legal standards.[161] At each of the three stages for committing suicidal individuals, the only determination required to keep the individual is the psychiatrist's or other psychiatric facility staff's personal assessment.[162] Even in the only civil commitment hearing required,[163] the psychiatrist is virtually "untouchable" when he or she determines, by "probable cause" only, that the individual is suicidal enough to

153. *See id.*

154. Kumho Tire Co. v. Carmichael, 526 U.S. 137, 148 (1999).

155. *Id.*

156. The *Daubert* test for expert testimony requires 1) permitted methods and procedures, 2) standards that control the procedures, 3) risks behind these methods, 4) industry acceptance of the methods, and 5) and procedures review by peers in the same industry. *See* Daubert v. Merrell Dow Pharms., Inc., 509 U.S. 579, 589–95 (1993).

157. Hart, *supra* note 66, at 125.

158. *Id.* at 127, 132.

159. *Id.* at 132 (citations omitted).

160. *Id.* at 135 ("The psychiatrist must not be allowed to remain in the position of an unimpeachable expert."). Even in pre-trial detentions of alleged criminals, the Supreme Court said that not only does the state have to show "*probable cause*" for the crime, but also the state must, in a "full blown adversary hearing, . . . convince a *neutral* decisionmaker by *clear and convincing evidence that no conditions of release can reasonably*" alleviate the danger. *Salerno*, 481 U.S. at 751 (emphasis added).

161. Hart, *supra* note 66, at 113–14, 125–26.

162. CAL. WELF. & INST. CODE §§ 5150(c) (for initial 72-hours), 5250(a) (for first 14-day extension), 5260(a) (for second 14-day extension); *see also* Warren, *supra* note 6, at 630–31.

163. The hearing is only required for the first 14-day extension. For the second 14-day extension, no hearing is required. *See supra* Part IV.A for a discussion on the issues with the lack of a hearing.

warrant involuntary commitment.[164] Not only does the LPS not provide suicidal individuals with a truly adversarial hearing, it also does not require the "unimpeachable" psychiatrist to convince a neutral party, by "clear and convincing evidence," that there are not less restrictive ways to protect the suicidal individual from committing suicide. The lack of any due process in the LPS highlights a stark deviation from the Supreme Court's requirements in *United States v. Salerno*, showing once again that suicidal individuals have less rights than criminals. This is a massive assault on the suicidal individual's Constitutional right to due process and fails strict scrutiny because the LPS allows psychiatrists to abuse their unwarranted, and often overinclusive, power to arbitrarily and unnecessarily deprive individuals of their fundamental rights.[165]

E. Strict Scrutiny and Furtherance of State Interest: Therapeutic Appropriateness and the Harms of Involuntary Commitments

Since the Supreme Court requires that the involuntary commitment be related to the purpose of the commitment, hospitalization should decrease suicidal behavior in patients held on involuntary holds for the commitment to be constitutional.[166] Under strict scrutiny, the LPS should also further California's interest in preserving life and preventing suicide.[167] Yet, with involuntary commitments of suicidal individuals, neither of these Constitutional requirements are true.

1. Treating Suicidal Tendencies During an Involuntary Commitment

Simply postponing a suicide is not enough justification to deprive the individual of liberty.[168] There is no evidence that involuntary treatment is effective,[169] and the sheer nature of "involuntary" makes it difficult for suicidal individuals to be amenable to hospital treatment.[170] Patients will resent the psychiatrists as "imprisoners" and will tend to reject treatment suggestions.[171] On the other hand, patients tend to make more progress in treatment

164. Hart, *supra* note 66, at 125.

165. *Id.* at 126–27; STEFAN, *supra* note 2, at 117 (people tend to be committed not because they are imminently suicidal but because they are accessible to psychiatrists).

166. *Jackson*, 406 U.S. at 738.

167. *Foucha*, 504 U.S. at 80.

168. *See* WINICK, THERAPEUTIC JURISPRUDENCE APPLIED, *supra* note 11, at 166 (using involuntary commitments just because people do not agree with suicide is "inappropriate absent therapeutic justification").

169. WINICK, CIVIL COMMITMENT, *supra* note 7, at 23; Mary L. Durham & John Q. La Fond, *A Search for the Missing Premise of Involuntary Therapeutic Commitment: Effective Treatment of the Mentally Ill*, 40 RUTGERS L. REV. 303, 355 (1988).

170. *See* WINICK, THERAPEUTIC JURISPRUDENCE APPLIED, *supra* note 11, at 137.

171. *Id.*

when they have some autonomous control over their healthcare.[172] Since suicidal individuals can refuse treatment within a hospital until separately proven incompetent, there seems to be little to no effectiveness to involuntary commitments other than temporarily delaying a suicide.[173]

2. Harms to Suicidal Individuals, Mental Health Professionals, and Society from Involuntary Commitment Laws

However, the harms that result from these laws are far worse than the inability to effectively treat suicidal patients. When suicidal individuals are involuntarily committed, the state implies that the individuals are incompetent, a label that can become a self-fulfilling prophecy and damage what little hope that kept the person alive.[174] Studies have also shown that involuntary commitments not only do not help,[175] but also may sharply increase suicidality.[176] On top of not reducing the risk of suicide, psychiatric hospitals can also traumatize patients[177] and even contribute to their ultimate suicide.[178]

172. WINICK, CIVIL COMMITMENT, *supra* note 7, at 27–30; WINICK, THE RIGHT TO REFUSE, *supra* note 26, at 343.

173. *See, e.g.*, CAL. WELF. & INST. CODE § 5325.2 (giving suicidal individuals the right to refuse medication at all three stages of commitment).

174. STEFAN, *supra* note 2, at 51, 289 (involuntary commitments can increase suicide by removing what little hope the individual had left); WINICK, THERAPEUTIC JURISPRUDENCE APPLIED, *supra* note 11, at 165.

175. STEFAN, *supra* note 2, at 2; Durham & La Fond, *supra* note 169, at 367.

176. Within the first three months after release, the rate of suicide in those individuals was fifteen times higher than in the general population of the United States. Daniel T. Chung et al., *Suicide Rates After Discharge from Psychiatric Facilities: A Systematic Review and Meta-Analysis*, 74 JAMA PSYCHIATRY 694, 695. *See also* Joshua T. Jordan & Dale E. McNiel, *Perceived Coercion During Admission into Psychiatric Hospitalization Increases Risk of Suicide Attempts After Discharge*, 50 SUICIDE LIFE-THREATENING BEHAV. 180, 180, 183 (2020) (finding that involuntary treatment, or the perception thereof, significantly increases suicide rates after release).

177. A study showed that 69% of participants were traumatized by involuntary treatment, with the most common reason being involuntary hospitalization. Diana Paksarian et al., *Perceptions of Hospitalization-Related Trauma and Treatment Participation Among Individuals with Psychotic Disorders*, 65 PSYCHIATRIC SERVS. 266, 267 (2014); *see also* Aditya Sareen et al., *Trauma from Involuntary Hospitalization and Impact on Mental Illness Management*, 24 PRIMARY CARE COMPANION CNS DISCORD (2022), https://www.psychiatrist.com/pcc/trauma-from-involuntary-hospitalization-impact-mental-illness-management/; Simone Chérie, *"I'm Sane, I Swear!": The Trauma of Involuntary Treatment: Temporary Symptoms, Long-Term Suffering*, MEDIUM (Aug. 30, 2018) ("involuntary admission everywhere can leave patients scarred"), https://medium.com/antiparty/recovering-from-the-trauma-of-treatment-5f972a42c21d.

178. Nate Burell, a former marine who committed suicide in 2020, is an example. In his suicide note, he described the effects of his psychiatric hospitalization: "I checked myself into the hospital for wanting to commit suicide and from the beginning I felt like a criminal going to jail. Stripped of my dignity and identity and personal property. I needed my family and friends during this time and you took that away. Not being able to communicate put me in such a darker hole than I was in originally that was so hard on me mentally. I would have told you anything to get me out of that place even if it meant I was okay when I wasn't. You didn't help me you held me prisoner so I couldn't hurt myself?" Luke Kenton, *60 Days In Star Nate Burrell, 33, 'Shoots Himself Dead in*

Involuntary commitment laws also allow the continuing stigma and abuse of suicidal individuals in institutions outside the hospital, such as institutions of higher learning.[179] Many universities can force students to take a leave of absence if the student is deemed suicidal or even self-harming.[180] Readmission processes can be so grueling that the leave of absence can function as an expulsion. Not only do these policies deter students from seeking treatment,[181] but they can also downright push students to commit suicide.[182]

University policies and involuntary commitment laws undermine the state's goal of preventing suicide by making it difficult to identify suicidal individuals who need treatment, making the law underinclusive as well. With the increase in mental health awareness comes an increased knowledge of the possible dangers behind asking for help. "It's OK to not be OK" does not apply if a patient says the wrong thing, leading even those without suicidal thoughts to be wary of treatment.[183] Those who do seek treatment have learned to completely avoid the topic of suicide during treatment.[184] Even therapists and psychiatrists are thwarted in their efforts by these laws because they know that a patient's fears of involuntary commitment will prevent the

Public' Just Hours After Posting Message to Facebook Saying 'I Can't Keep Going On', DAILY MAIL (Nov. 1, 2020, 1: 48 PM), https://www.dailymail.co.uk/news/article-8902969/60-Days-star-Nate-Burrell-33-shoots-dead-public.html.

179. Even within healthcare, a label of mental illness can cause other physicians to overlook even fatal illnesses. STEFAN, *supra* note 2, at 373.

180. *Id.* at 392; Rachel Williams, *"We Just Can't Have You Here"*, YALE DAILY NEWS (Jan. 24, 2014, 2:05 AM), https://yaledailynews.com/blog/2014/01/24/we-just-cant-have-you-here/ (describing experience of Yale student forced to take a medical leave of absence after going to the hospital for cutting herself).

181. William Wan, *'What if Yale Find Out?'*, WASH. POST (Nov. 11, 2022, 7:00 AM), https://www.washingtonpost.com/dc-md-va/2022/11/11/yale-suicides-mental-health-withdrawals/ (Students "learned to hide mental problems and suicidal thoughts to avoid triggering withdrawal policies.").

182. Yale student Yichuan Wang committed suicide, writing in her note that she was worried if she took a second leave of absence for mental health, she would not be readmitted to Yale. Rachel Siegel & Vivian Wang, *Student Death Raises Questions on Withdrawal Policies*, YALE DAILY NEWS (Jan. 29, 2015, 2:39 AM), https://yaledailynews.com/blog/2015/01/29/student-death-raises-questions-on-withrawal-policies/.

183. Michael T. Nietzel, *Almost Half of Americans Don't Seek Professional Help for Mental Disorders*, FORBES (May 24, 2021, 9:10 AM), https://www.forbes.com/sites/michaeltnietzel/2021/05/24/why-so-many-americans-do-not-seek-professional-help-for-mental-disorders/?sh=2d7243c73de7; *see also* WINICK, CIVIL COMMITMENT, *supra* note 7, at 27.

184. David J. Hallford, *Most People Don't Disclose Their Suicidal Thoughts: Here's Why and What We Can Do About It.*, PSYCH. TODAY (Apr. 22, 2023), https://www.psychologytoday.com/us/blog/our-wonderful-messy-minds/202304/we-dont-talk-about-ending-our-lives. Patients are also less likely to share thoughts with their outpatient providers after a hospitalization that could warrant another. Awais Aftab et al., *Impact of Psychiatric Hospitalization on Trust, Disclosure and Working Alliance with the Outpatient Psychiatric Provider: A Pilot Survey Study*, 11 CUREUS (2019), https://www.cureus.com/articles/19258-impact-of-psychiatric-hospitalization-on-trust-disclosure-and-working-alliance-with-the-outpatient-psychiatric-provider-a-pilot-survey-study#!/.

patient from being open and honest regarding all of their health needs.[185] No provider can fully convince an individual to trust that he or she could never be committed.

Even outpatient mental health professionals are negatively impacted by the LPS, as they can still be sued and found liable for not committing a suicidal patient if there was reason to believe the patient was in danger.[186] This is a common concern for outpatient providers.[187] But research shows that these fears are misguided because there is a disconnect between legal causes of actions a lawyer may actually bring and what mental health providers think they will be sued for.[188] In fact, suicidal patients or surviving family members are less likely to sue providers they believe actually cared,[189] and lawyers rarely pursue cases involving suicide.[190] Ironically, the sheer fear of litigation can impede the provider's treatment and instead increase the perception that there was a lack of care for the patient, which would, in turn, increase the chances of litigation.[191] If providers did not have an involuntary commitment law to turn to, much of this fear would be abated, and suicidal patients could receive better care.

The negative impact on so many groups of people shows that involuntary commitment laws, such as the LPS, utterly fail under strict scrutiny for being over-inclusive and ineffective in carrying out the state's interest. People who are not suicidal can be wrongfully committed and people who are truly suicidal often attempt to avoid detection, ultimately producing the opposite effect of what the laws trying to prevent suicide intended.

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185. WINICK, CIVIL COMMITMENT, *supra* note 7, at 32–33 (patient-therapist trust can be damaged by involuntary commitments); WINICK, THE RIGHT TO REFUSE, *supra* note 26, at 338 (trust between patient and therapist is crucial for effective treatment); Tamara Hill, *Involuntary Hospital Commitment: What You Should Know*, ANCHORED CHILD & FAM. COUNSELING (Aug. 27, 2017), https://www.anchoredinknowledge.com/involuntary-commitment-what-you-should-know/.

186. *See* Kockelman v. Segal, 71 Cal. Rptr. 2d 552, 558 (Cal. Ct. App. 1998) (holding that outpatient psychiatrists owe the same duty of care to suicidal patients as inpatient psychiatrists when there is reason to believe the patient may commit suicide).

187. Herbert Hendin et al., *Factors Contributing to Therapists' Distress After the Suicide of a Patient*, 161 AM. J. PSYCHIATRY 1442, 1443 (even a "*potential* lawsuit by relatives who blamed the therapist for the suicide was the cause of severe distress [for mental health providers].") (emphasis added).

188. STEFAN, *supra* note 2, at 297, 300. In fact, a study showed psychiatrists were the least likely to be sued among physicians at only 2.6% with even fewer lawsuits that resulted in any liability. Anupam B. Jena et al., *Malpractice Risk According to Physician Specialty*, 365 NEW ENG. J. MED. 629, 632 (2011).

189. *See* STEFAN, *supra* note 2, at 298 (citations omitted).

190. *Id.* at 300.

191. Being overly cautious and committing suicidal patients who could have been treated in an outpatient setting can "increase [the] risk of litigation" and "undermine a valuable treatment alliance." Douglas Mossman, *Defensive Medicine: Can It Increase Your Malpractice Risk?*, 8 CURRENT PSYCHIATRY 86, 87 (2009).

F. Strict Scrutiny and Less Restrictive Alternatives

Under strict scrutiny, involuntary commitments must also be the least restrictive option for suicidal individuals.[192] Between inpatient treatment and traditional outpatient treatment (such as hour-long therapy sessions), there are two other common levels of care: partial hospitalization programs ("PHPs") and intensive outpatient programs ("IOPs").[193] In fact, many psychiatric patients transition to one of these two programs after an inpatient hospitalization.[194] PHPs are an intermediate between inpatient and full outpatient care, where patients are typically in treatment for around six hours a day, five days a week.[195] However, patients can still return to the comfort of their own homes and have the freedom to carry out regular activities.[196] IOPs allow for even more freedom, typically involving only around three hours of treatment a day, three days a week.[197] While there is an argument to be made that these are not viable options for crisis intervention of suicidal individuals, after the initial Section 5150 hold, these two options are certainly preferable to another twenty-eight days in a psychiatric hospital.[198] Allowing psychiatrists to legally force suicidal patients into one of these programs is better

192. *Salerno*, 481 U.S. at 751 (requiring the state to show that there was no other option for protecting the public from a dangerous individual other than a pre-trial involuntary detention).

193. Molly Schiffer, *Understanding Levels of Care in Mental Health Treatment*, ANXIETY & DEPRESSION ASS'N AM. (Sept. 20, 2023), https://adaa.org/learn-from-us/from-the-experts/blog-posts/consumer-professional/understanding-levels-care-mental. Residentials are also an example of less intensive treatment. However, these also involve the individual living 24/7 in a facility for several months. Even though it is slightly less restrictive, it is still a complete deprivation of bodily liberty as the individual is still not free to interact with the outside world. The only substantial difference between residentials and inpatient is the setting. *Id.* As such, this note will not treat residentials as a less restrictive alternative to involuntary commitments. In fact, it may even be worse given the duration.

194. *See* Theodora Blanchfield, *How an Intensive Outpatient Program (IOP) Works*, VERYWELL MIND (Nov. 21, 2023), https://www.verywellmind.com/what-is-an-iop-intensive-outpatient-program-5521766#toc-what-to-expect-in-an-iop; RISE ABOVE TREATMENT, *Introduction*, https://www.riseabovetreatment.com/partial-hospitalization-program-california/ (last visited Nov. 30, 2023).

195. *See, e.g.*, UCLA HEALTH, *Adult Partial Hospitalization Program (PHP)*, https://www.uclahealth.org/hospitals/resnick/partial-hospitalization-intensive-outpatient/adult-partial-hospitalization-intensive-outpatient-programs/adult-partial-hospitalization-program-php (last visited Nov. 30, 2023) [hereinafter UCLA HEALTH, *Adult PHP*]; RISE ABOVE TREATMENT, *supra* note 194.

196. RISE ABOVE TREATMENT, *supra* note 194.

197. *See, e.g.*, Blanchfield, *supra* note 194; UCLA HEALTH, *Adult Intensive Outpatient Program (IOP)*, https://www.uclahealth.org/hospitals/resnick/partial-hospitalization-intensive-outpatient/adult-partial-hospitalization-intensive-outpatient-programs/adult-intensive-outpatient-program-iop (last visited Nov. 30, 2023) [hereinafter UCLA HEALTH, *Adult IOP*].

198. Besides, if the LPS properly applied Supreme Court and constitutional standards, most suicidal individuals would not be eligible for involuntary commitments after the initial 72-hour hold. *See* STEFAN, *supra* note 2, at 121.

than the current structure.[199] There would still be issues with depriving individuals of their right to self-determination, but at least there would not be a full deprivation of bodily liberty.

On a larger scale, Susan Stefan suggests that addressing suicide as a public health issue, while subtle, may be more effective.[200] Increasing regulations may decrease the rate of suicide from common methods such as guns, poison, trains, and bridges.[201] For example, the Golden Gate Bridge in California, where Yale student Yichuan Wang committed suicide, is the "number one suicide site in the world,"[202] made easy by the fact that its railings are only three-and-a-half feet tall, the exact minimum height requirement under California law.[203] Even though the state can clearly foresee (and has seen) the ever-increasing suicides off this bridge,[204] it still has not required any effective undertakings to alleviate this danger.[205] The lack of action is surprising, as even a simple barrier could effectively deter suicide by making it more difficult to attempt.[206] A psychiatrist could be liable for not preventing a suicide if he or she had reason to see it coming,[207] which is difficult to predict and damaging to the patient-provider relationship.[208] However, given the numerous well-documented suicides and attempts off the Golden Gate Bridge, the state does not face the same issue of foreseeability and the fix is

199. In fact, California already allows for psychiatrists to force outpatient treatment on patients who would otherwise not pursue it. *See generally* Laura's Law, CAL. WELF. & INST. CODE §§ 5345–5349.5 It would not be a matter of first impression to include PHPs and IOPs in exchange for tightening the requirements for additional 14-day treatments in a psychiatric hospital.

200. STEFAN, *supra* note 2, at 419 ("even if individual suicides cannot be predicted, the suicide rate as a whole can be reduced."); Mel Blaustein & Anne Fleming, *Suicide from the Golden Gate Bridge*, 166 AM. J. PSYCHIATRY 1111, 1114 ("reducing access to lethal means is an effective strategy in reducing suicide.").

201. *See generally* STEFAN, *supra* note 2, at 419–39.

202. Blaustein & Fleming, *supra* note 200, at 1111. Suicide attempts from the Golden Gate Bridge have a 98% fatality rate. Richard H. Seiden, *Where Are They Now?: A Follow-up Study of Suicide Attempters from the Golden Gate Bridge*, 8 SUICIDE & LIFE THREATENING BEHAV. 203, 209 (1978).

203. STEFAN, *supra* note 2, at 421.

204. Blaustein & Fleming, *supra* note 200, at 1113 tbl.1; Seiden, *supra* note 202, at 207 fig.1.

205. *See* STEFAN, *supra* note 2, at 422–43.

206. *Id.* at 421 (defeated attempts to not make attempts try again elsewhere); *see also* Seiden note 202, at tbls.4 &12 (finding that of the 515 individuals who survived jumping from the Golden Gate Bridge between 1937 and 1971, 35 or 6.8% went on to die by suicide, with only 7 of those returning to the Golden Gate Bridge). In four examples of barriers built on suicide-prone bridges, one bridge saw a decrease from twenty-four suicides to one, the second saw a complete elimination simply from making suicide more difficult rather than impossible, and the other two saw reductions by nearly half. Other bridges were nearby in all four instances but did not compensate for the decrease on the bridges with barriers. Blaustein & Fleming, *supra* note 200, at 1114–15.

207. *See supra* note 191 and accompanying text.

208. *See* discussion *supra* Part IV.C.

far simpler and less damaging.[209] Yet the state has not yet done anything about it, which casts doubt on whether California is truly pursuing a compelling state interest with the existence of the LPS.[210]

V. ARGUMENTS IN SUPPORT OF INVOLUNTARILY COMMITTING SUICIDAL INDIVIDUALS

There are countless reasons why some believe that suicide should be avoided at all costs. The following sections address some of these rationales. Some say suicide is a permanent solution to a temporary problem, suicide does not eliminate the pain but rather spreads it to others. Medical professionals took the Hippocratic Oath and are trained to prevent death, not let it slip by. Some even try to use numbers to prove that even suicidal individuals do not actually want to die. All are true: none justify involuntary commitments.

A. "Things Get Better" and "Suicide Spreads the Pain"

Two common rationales an individual may hear are "things get better" and "suicide hurts those around you."[211] Both are true, but neither is sufficiently convincing to justify the harm that suicidal individuals may suffer by being forced into a psychiatric hospital or by simply staying alive. It is true that things may get better for some, but are the odds of that happening worth it? If people could see into the future and determine with 100% accuracy that an individual's life would never get better and would forever remain in a state of suffering, most people would probably agree with the individual's decision to end his or her life. Similarly, if society knew what happened after death, even people who were never suicidal may take their own lives if they believed their afterlife would be better. Unfortunately, no one knows the future or what waits for them after death; so, the suicidal individual is left to weigh the possibilities. Shelly Kagan presented a hypothetical of two doors to demonstrate this choice.[212] One door has a 99.9% chance of leading to worse-than-death torture for the rest of one's life and a 0.01% chance of a

209. STEFAN, *supra* note 2, at 422.

210. *See* Church of Lukumi Babalu Aye, Inc. v. City of Hialeah., 508 U.S. 520, 546–47 (1993) ("Where government . . . fails to enact feasible measures to restrict other conduct producing substantial harm or alleged harm of the same sort, the interest given in justification of the restriction is not compelling."); STEFAN, *supra* note 2, at 419 ("Unfortunately, much of the evidence of our policies and our laws points to the conclusion that as a society, we really don't care at all.").

211. Crystal Raypole, *8 Reasons to Live, from a Text Crisis Counselor Who's Been There Before*, HEALTHLINE (Sept. 10, 2020), https://www.healthline.com/health/mental-health/reasons-to-live; Rebecca Ruiz, *21 Reasons to Keep Living When You Feel Suicidal*, MASHABLE (Mar. 21, 2023), https://mashable.com/article/suicide-want-to-die-reasons-to-keep-living.

212. YaleCourses, *Death with Shelly Kagan: 25. Suicide, Part II: Deciding under Uncertainty*, YOUTUBE, 16:00-24:31 (Sept. 30, 2008), https://www.youtube.com/watch?v=nKbV8NcyCrk.

"wonderful vacation" for that same amount of time.[213] The other door has a 100% guarantee of sleep that the person will simply never wake up from.[214] Hardly anyone would say that choosing the second door is irrational simply because the first door had a remote chance of resulting in a better outcome.[215] Of course, the possibility of recovering from the pain that drives suicidal thoughts may be greater than 0.01%, but there is also no way of determining the actual probability. Ironically, the suicidal individual faces the same statistical dilemma as that of psychiatrists trying to predict danger.[216] If individuals are incompetent for committing suicide without fully grasping the probability of results, does that not also make psychiatrists incompetent for involuntarily committing suicidal individuals without understanding the probabilities of suicide from danger?

The fact that one person's suicide can devastate others is also not in doubt, but this reasoning still does not justify depriving a suicidal individual of basic rights. First, the law has never denied fundamental rights based on whether a decision made about one's own body could psychologically hurt others.[217] Same-sex relations, abortions, and even birth-control are deeply frowned upon by certain religions.[218] Some people who hold strong convictions often believe that if someone they cared for committed any of those acts, that person's soul would be damned to suffer for eternity.[219] This can be devastating to the person holding this belief, yet that fact has never been part of the judicial reasoning for determining fundamental rights. Admittedly, suicide is different from those examples and may impact more people with greater severity, but a principle in property law regarding nuisance sheds some light here. In nuisance cases, plaintiffs can get injunctions against defendants even if the harm to the plaintiff without the injunction is considerably smaller, in absolute rather than relative terms than the harm to the defendant with the injunction.[220] The justification for this is that the plaintiff feels the smaller harm much more saliently than the defendant feels

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213. *Id.*

214. *Id.*

215. *Id.*

216. *See* discussion *supra* Part IV.C.2.

217. *See* cases cited *supra* note 11.

218. *See* PEW RSCH. CTR., *Religious Beliefs Underpin Opposition to Homosexuality* (Nov. 18, 2003), https://www.pewresearch.org/politics/2003/11/18/religious-beliefs-underpin-opposition-to-homosexuality/; PEW RSCH. CTR., *Religious Groups' Official Positions on Abortion* (Jan. 16, 2013), https://www.pewresearch.org/religion/2013/01/16/religious-groups-official-positions-on-abortion/; JG Schenker & V. Rabenou, *Contraception: traditional and religious attitudes*, 49 EUROPEAN J. OBSTETRICS & GYNECOLOGY AND REPRODUCTIVE BIOLOGY 15 (Apr. 1993), https://pubmed.ncbi.nlm.nih.gov/8365507/.

219. *See* RYAN E. Lawrence RE, et al., *Religion and Suicide Risk: A Systematic Review*, 20 ARCH SUICIDE RSCH. 1 (2016), doi: 10.1080/13811118.2015.1004494.

220. Whalen v. Union Bag & Paper Co., 101 N.E. 805, 805–06 (N.Y. 1913).

the larger harm.[221] Applying that reasoning to suicidal individuals, the overall pain spread to those left behind may be greater than the suffering the individual faced alone. However, the suicidal person clearly feels the pain more deeply than those left behind: the pain was substantial enough for the victim to choose death over life. If each of those left behind felt the same level of pain and desperation, then they too would have ended their own lives. Such a domino effect would have rendered the human race extinct long ago. It seems unreasonable to keep suicidal individuals alive simply to protect others from grief.

B. "First, Do No Harm" and "Thank You for Saving Me"

Before embarking on their medical careers, physicians take the Hippocratic Oath where they vow to keep patients safe and "first, do no harm."[222] One translation from the original Greek reads "I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice."[223] Since many physician's believe that death is the greatest harm that can befall a patient, failure to prevent a patient from committing suicide could feel like a violation of the oath.[224] The problem is that the Hippocratic Oath also requires psychiatrists not only to never intentionally hurt their patients but to also protect their patients from harm that may result from their own profession's practices, such as involuntary commitments.[225] As previously discussed, the harm to suicidal patients from involuntary commitments is far more established than the probability that a patient with suicidal behaviors will commit suicide.[226] In light of these findings, psychiatrists should be making an effort to protect their patients against involuntary treatments, rather than continue to hold on to the "delusional" belief that involuntary commitments are helpful.[227]

Stemming from the belief that involuntary commitments are helpful is the "thank you" theory, which is similar to the justification that states use to

221. *Id.* at 806 ("refusing an injunction . . . would deprive the poor litigant of his little property by giving it to those already rich.").

222. Darin D. Signorelli & Stephen Mohaupt, *Informed Consent and Civil Commitment in Emergency Psychiatry*, PSYCHIATRIC TIMES (May 1, 2007), https://www.psychiatrictimes.com/view/informed-consent-and-civil-commitment-emergency-psychiatry.

223. Peter Stastny, *Involuntary Psychiatric Interventions: Breach of the Hippocratic Oath?*, 2 ETHICAL HUM. SCIS. & SERVS. 21, 23 (2000) (citation omitted).

224. SAKS, *supra* note 116, at 12, 76.

225. Stastny, *supra* note 223, at 23.

226. *See* discussion *supra* Parts IV.D and IV.E.2.

227. SAKS, *supra* note 116, at 185 (defining delusional belief as beliefs that "remain despite evidence to the contrary.").

exert *parens patriae* power.[228] This is a belief that once restored to full health, patients will thank their providers for their involuntary interventions.[229] Their training and society's increasing belief that "everyone can recover" lead psychiatrists to believe that patients simply cannot comprehend the possibility of improvement on their own.[230] Unfortunately, there is little to no evidence that psychiatric patients ever appreciate involuntary efforts.[231] On the contrary, patients may recognize the positive effects of the treatment but nonetheless resent the involuntary procedure.[232]

Both of these reasons show that there are psychiatrists who truly care for their patients but are attempting to treat them in a counterproductive manner. An increased awareness of the harms to suicidal patients from involuntary commitments and the availability of less coercive options could substantially help these providers treat their patients more effectively. Using the "thank you" theory and *parens patriae* rationale, psychiatrists may even benefit from legal rules that strictly confine them to practicing non-coercive medicine if they are currently unable to realize the benefits of this themselves.[233] Not only would this allow psychiatrists to better protect their patients from the harms of suicide, but it would also allow them to fulfill their Hippocratic duty of protecting patients from the likely harms resulting from involuntary psychiatric treatment.[234]

C. "You Would Regret It"

None of the above is intended to diminish the importance of preventing suicide. It does, however, demonstrate that involuntary commitments are not the best avenue to address the problem.[235] A very important reason to prevent suicides connects both the thought that circumstances will get better and the "thank you" theory: people who commit suicide could have gone on to live full lives had the attempt not been successful. The reasoning is backed by research on suicide-attempt survivors, many of whom will not attempt

228. *Id.* at 12; Dora W. Klein, *Memoir as Witness to Mental Illness*, 43 L. & PSYCH. REV. 133, 159 (2019). *See supra* Part II.A for a discussion on *parens patriae* power.

229. Klein, *supra* note 228, at 159.

230. STEFAN, *supra* note 2, at 288–89.

231. Stastny, *supra* note 223, at 23.

232. Klein, *supra* note 228, at 159.

233. *See* Stastny, *supra* note 223, at 35 ("[A]ny physician wanting to observe the Hippocratic Oath must stand in the way of these practices and do the utmost to search for noncoercive solutions. Perhaps these 'conscientious objectors' would then be considered . . . 'Hippocratic Oath Practitioners' in contrast to those who practice social control under the guise of psychiatric treatment.").

234. *Id.* at 23.

235. *See supra* Part IV.F and *infra* Part VI.A.1.e for discussions on least restrictive alternative in California.

suicide again.[236] Importantly, there is no omitted variable bias as successful attempts do not correlate with stronger suicidal intent.[237] There are individuals with high levels of intent to die who use less lethal methods because that is all they have access to.[238] There are people with lower intent to die who may end up successfully ending their lives because they were not aware of the lethality of the methods they used.[239] Regardless of the combination of method lethality and intent to die, those who survive a suicide attempt rarely follow through with a completed suicide.[240] Physicians may view these data as a compelling reason to use the LPS to commit individuals who may attempt to not risk those individuals falling into the 10% of suicide completers.[241] However, these numbers represent all those who attempted suicide, not just those who were hospitalized for an attempt. Thus, these numbers show that decreasing the fatality of an attempt to increase survival probability may be far more effective at preserving life and far less restrictive on the fundamental rights of self-determination and liberty.[242]

VI. PROPOSED CHANGES TO THE LAW

The LPS has undoubtedly provided far better rights to suicidal individuals and should be applauded for its efforts.[243] By putting a limit on the time a suicidal individual can be committed[244] and providing separate laws for involuntary commitments of suicidal individuals,[245] it provides a process worthy of emulation.[246] However, the LPS simultaneously deprives suicidal individuals of rights previously granted by the Supreme Court while also

236. Stacey Freedenthal, PhD, LCSW, actually finds this to be the most compelling reason to prevent suicide, stating: "The most important reason to prevent suicide is that suicidal crises, though formidable and painful, almost always are temporary. Even if the person continues thinking about suicide, the intense suicidal intent usually subsides. Consider that 90% of people who survive a suicide attempt do not go on to die by suicide. That number is very revealing. Even among people who wanted to die so strongly that they tried to end their life, most ultimately chose to live." Freedenthal, *Why Prevent Suicide? Here Are My Reasons.*, SPEAKING OF SUICIDE (May 19, 2013), https://www.speakingofsuicide.com/2013/05/19/why-stop-someone-from-suicide/.

237. HARV. SCH. PUB. HEALTH, *Method Choice and Intent*, https://www.hsph.harvard.edu/means-matter/means-matter/intent/ (last visited Nov. 30, 2023).

238. *Id.*

239. *Id.*

240. *Id.*

241. *Id.*

242. *Id.*; *see* discussion *supra* Part IV.F.

243. CAL. WELF. & INST. CODE § 5001; *see also* Hart, *supra* note 66, at 98; Lenell, *supra* note 126, at 733; Morris, *supra* note 67, at 77; Warren, *supra* note 6, at 630.

244. CAL. WELF. & INST. CODE §§ 5250, 5264; Warren, *supra* note 6, at 630.

245. CAL. WELF. & INST. CODE §§ 5260–5268; Hart, *supra* note 66, at 101; Morris, *supra* note 67, at 76.

246. Warren, *supra* note 6, at 630.

failing to address long-standing shortcomings of involuntary commitment laws and procedures and ignores the basic requirements to exert *parens patriae* power.[247] Changes to the LPS that it make it far more difficult, if not impossible, to commit suicidal individuals are warranted because a complete deprivation of fundamental rights is at stake.[248] As it currently stands, the LPS is impeding otherwise effective methods to help suicidal individuals, and more limitations on the law are likely to improve these impediments.[249]

A. Modifying Requirements and Process of Committing Suicidal Individuals

Should California continue to use the LPS for committing suicidal individuals, certain changes must made to the current requirements and procedures, specifically regarding Section 5250 and Section 5260 holds. Since the Section 5150 hold is relatively brief and usually used for crisis intervention purposes, the proposed changes would not be applicable to it.[250] Additionally, Section 5150 holds perform the function of thwarting suicide attempts, something that has shown to be effective in reducing suicide.[251] The proposed changes below will support a psychiatrist's focus on patients' suicidality without diminishing the patient's suffering to a treatable mental illness and to support the autonomy of suicidal individuals, even though the process may be ultimately involuntary.[252]

1. Elements

The first set of changes involve adding certain requirements and clarifying the definitions of existing terms.[253] These proposed changes are tailored specifically to suicidal individuals, as is required by the Supreme Court

247. *See* Lenell, *supra* note 126, at 735 (the LPS's "failure to provide effective treatment undermines the state's resort to the *parens patriae* power to justify confinement of those who are not dangerous to others."); Warren, *supra* note 6, at 631.

248. Vitek v. Jones, 445 U.S. 480, 491 (1980) (involuntary commitments are "'a massive curtailment of liberty'") (citation omitted); *see* Morris, *supra* note 67, at 83–85.

249. Critics of the LPS were worried that the LPS would impede treatment by giving patients more rights, but this did not turn out to be true. Hart, *supra* note 66, at 134.

250. Even alleged criminals can be arrested and detained before they are convicted for longer imprisonments.

251. *See* discussion *supra* Part IV.F.

252. STEFAN, *supra* note 2, at 103 ("The problem of suicide should be addressed directly, phenomenologically, without the intervention of the often obfuscating variable of psychiatric disorder") (citation omitted). The MacArthur study on coercion showed that just the perception of coercion, whether or not there was any legal compulsion, could impact patients and treatment. *See* WINICK, CIVIL COMMITMENT, *supra* note 7, at 25; WINICK, THE RIGHT TO REFUSE, *supra* note 26, 343.

253. Lenell, *supra* note 126, at 737 ("In order to satisfy the demands of due process, a law which serves as a basis for confining individuals must not be vague."); *see* cases cited *supra* note 31.

for involuntary commitments.[254] In short, for both Section 5250 and Section 5250 holds, the LPS should limit the frequency of these holds and require at least "clear and convincing" findings of 1) incompetency, 2) a mental illness that leads to 3) an imminent danger of suicide, 4) therapeutic appropriateness of the hospitalization, and 5) no other effective, less restrictive treatments are available in truly adversarial hearings.

a. Competency

The LPS does not currently require competency, which is a blatant violation of autonomy, as *parens patriae* requires the individual to be unable to make decisions for themselves.[255] Even though incompetency is so often assumed for suicidal individuals, legally this has never been the case.[256] In fact, for healthcare decisions, competency is to be assumed, and the burden is on the psychiatrist to prove otherwise, as is required to exert *parens patriae* power.[257] Outside the LPS, California currently defines competency as a "person's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives."[258] The LPS should use this definition as a starting point and supplement it with inquiries specifically for suicidal people. The consequences of suicide are not just death but also damage to others and the loss of experiencing a potentially bright future.[259] For suicidal individuals, psychiatrists should be required to ask patients how well they understand these consequences by presenting them with well-founded evidence.[260] A proposed set of questions and order is:

I. Can you tell me some specific reasons that you want to end your life?
   A. ***[Patient answers "yes"]***: I'm glad you're able to articulate this. Do you feel that living with these problems is worse than death?
      i. ***[Patient answers "yes"]***: I can't imagine how painful this must be. If these reasons were to magically go away today, would you stay alive?

254. *Hendricks*, 521 U.S. at 358; *see also* SAKS, *supra* note 116, at 33.

255. *See Jackson*, 406 U.S. at 731; *see also* discussion *supra* Part II.A.

256. *See* STEFAN, *supra* note 2, at 13–14; Annas & Densberger, *supra* note 15, at 565. *See supra* Part II for an analysis on the trend of labeling suicidal individuals as incompetent.

257. Annas & Densberger, *supra* note 15, at 575 (citation omitted).

258. CAL. PROB. CODE § 4609.

259. *See* discussion *supra* Part V.

260. Providing patients with evidence is imperative as it can help psychiatrists differentiate between individuals who truly have issues with comprehension and those who simply have differing conviction. *See* SAKS, *supra* note 116, at 185.

a. ***[Patient answers "yes"]***: I'm glad to hear that. Why don't we try to figure out some ways to fix these issues first?[261]
b. ***[Patient answers "no"]***: That must be overwhelming. Can you tell me more about why you would want to end your life even if these problems disappeared?

ii. ***[Patient answers "no"]***: I understand that these reasons are overwhelming, but I'm glad to hear you say that death would not be answer. How about we find some ways for you to solve these problems so that you don't have to keep living in pain?

B. ***[Patient answers "no"]***: That must be very frustrating in addition to painful. Can you tell me more about your motivation to end your life then?

II. Can you tell me about any people you deeply care about?

A. ***[Patient answers "yes"]***: I'm glad to hear that. A close community is very important in life. Do you think they would be devastated by your death?

i. ***[Patient answers "yes"]***: I'm glad you recognize that. Are you willing to succumb to them to the pain of losing you?

a. ***[Patient answers "yes"]***: That must be a difficult decision. Can you tell me more about why you would be willing to hurt those you care about?
b. ***[Patient answers "no"]***: That's very compassionate. I'm sure they don't want to see you suffer either. Why don't we find methods that can help you live without this unbearable pain while also protecting those you care about from losing you or seeing you suffer?

ii. ***[Patient answers "no"]***: I'm sure those people care more than you think. I'll bet there are people in your life who have made a positive impact on you without knowing it, and you've done the same for others. Would you still be willing to inflict the

261. This would not only address the requirement for least restrictive options but also assess whether hospitalization is appropriate, which is already required for the initial 72-hour detention. CAL. WELF. & INST. CODE § 5150(c).

grief of losing you if you knew they would be devastated?

a. ***[Patient answers "yes"]***: That must be a difficult choice. Can you tell me more about why you would be willing to risk hurting those you care about?

b. ***[Patient answers "no"]***: I'm glad to hear that. Why don't we find methods that can help you live without this unbearable pain without the risk of hurting those you care about?

B. ***[Patient answers "no"]***: You seem like a kind and caring person. Can you tell me more about why there is no one in your life you care about?

III. I understand you believe that things cannot get better, but let's assume that I have a crystal ball that can predict the future.[262] It tells you that you will definitely get better if you stay alive, but it does not tell you when. How long would you be willing to wait?

A. ***[Patient answers "X amount of time"]***: I'm so glad to hear you still have hope. How about you wait until then to revisit this decision?

B. ***[Patient answers "never"]***: I can't imagine how much pain you must be going through. Can you tell me more about why you feel you cannot live with this pain any longer?

IV. Do you understand that the majority of people who survive a suicide attempt do not go on to complete the attempt in the future[263] and that some people instantly regret their decision?[264]

A. ***[Patient answers "yes"]***: That shows a lot of awareness. Do you believe you would regret your decision or at least not make another attempt if this one were unsuccessful?

i. ***[Patient answers "yes"]***: That's very introspective. Why don't we find ways to alleviate your pain so that the intensity does not make you do something you would regret?

262. *See* YaleCourses, *supra* note 212.

263. Seiden, *supra* note 202, at 209; HARV. SCH. PUB. HEALTH, *supra* note 237.

264. For example, Kevin Hines survived a jump from the Golden Gate Bridge and recounted that he regretted his decision the moment he stepped on the ledge. Frances Weller, *'It Was Instant Regret': Golden Gate Bridge Suicide Survivor to Share Story in Virtual Event in Wilmington*, WECT NEWS 6 (Nov. 17, 2020, 9:57 AM), https://www.wect.com/2020/11/17/it-was-instant-regret-golden-gate-bridge-suicide-survivor-share-story-virtual-event-wilmington/.

ii. ***[Patient answers "no"]***: Seems like you've thought this through. Can you tell me more about why you think this isn't a decision you would regret?

B. ***[Patient answers "no"]***: Let me show you some studies and examples. Do you feel these numbers are convincing?

i. ***[Patient answers "yes"]***: I'm glad to hear that. Do you believe you would regret your decision or at least not make another attempt if this one were unsuccessful?

a. ***[Patient answers "yes"]***: That's very introspective. Why don't we find ways to alleviate your pain so that the intensity does not make you do something you would regret?

b. ***[Patient answers "no"]***: Seems like you've thought this through. Can you tell me more about why you think this isn't a decision you would regret?

ii. ***[Patient answers "no"]***: I'm sorry to hear that. Would you be willing to discuss your reservations about these studies with me more?

a. ***[Patient answers "yes"]***: If I can address your concerns, do you believe that you may regret your decision to die?

1. ***[Patient answers "yes"]***: I'm glad you're keeping an open mind. Let's discuss some of your thoughts. Can you tell me why don't find these studies compelling and I will do my best to collect information to address your concerns?

2. ***[Patient answers "no"]***: It seems like your mind is set. Can you tell me more about why you think you would be an exception to regretting suicide?

b. ***[Patient answers "no"]***: Data is very helpful for making informed decisions, and you seem like someone who is thinking about your decision carefully. Can you tell me more about why you wouldn't want to

see how others in similar situations have reacted?

If the patient seems to be unwilling to engage in any kind of analysis of their decision that would deter them from committing suicide—such as saying he or she simply does not care if things get better no matter the probability or evidence against their reasoning—then a psychiatrist may be able to consider this as the patient's inability to fully understand the nature of their decision.[265] This is not to say that patients cannot give cogent answers as to why they do not want to wait and will require some clinical assessment, but at the very least, psychiatrists can use these in court to support an involuntarily commit of the patient.

Additionally, this proposition evaluates competency separate from mental illness. While some mental illnesses cause incompetency, not all do.[266] Some patients may be affected by incompetency as a result of their mental illness while others may not. Likewise, other patients may maintain their competency despite their mental illness while many others lose their competency. The inconsistency of how individuals experience mental illness highlights how important it is to evaluate a person's competency separately from their possible mental illness diagnosis.

b. Mental Illness

The LPS should specifically define what a "mental illness" is for the purposes of involuntarily committing a suicidal individual with a definition that abides by a legal standard, not the definition the DSM-V.[267] Since the DSM-V currently only includes suicidal behavior as symptoms of Major Depressive Disorder and Borderline Personality Disorder, legally defining a mental illness with the DSM-V's definition limits psychiatrists to only two diagnoses when committing a suicidal individual.[268] Not only does this overlook other mental illnesses that could result in suicide, but it also puts a potentially damaging and stigmatizing label on individuals who may not suffer from either disorder. Instead, this note proposes that the LPS define "mental illnesses" for involuntarily committing suicidal individuals either as DSM-V illnesses that have scientifically supported association with suicidal behavior,[269] or as behavior, potentially without an underlying mental illness,

265. Elyn Saks proposed defining incompetency to include delusional beliefs that are held "despite evidence to the contrary." SAKS, *supra* note 116, at 185.

266. *See* discussion *supra* Part II.

267. *See* discussion *supra* Part IV.C.1.

268. DSM-V, *supra* note 37, at 160–68, 663–66.

269. This should be vetted in accordance with the *Daubert* test for expert testimony.

that indicates an imminent threat of suicide.[270] Because one of the LPS's purposes is to prevent suicide, the updated definition allows psychiatrists to focus only on the suicidal aspects of individuals and thus be more narrowly tailored to the LPS's purpose.

c. Danger

Assuming that psychiatrists could predict danger with accuracy, the time and severity of danger must be narrowly defined for Section 5250 and Section 5250 commitments of suicidal individuals.[271] As each of the holds are for fourteen days, at each stage, "imminent danger" should require that the suicidal individuals will attempt suicide within that period.[272] Since there is no evidence that hospitalization decreases the chances of suicide upon discharge, holding an individual for a period where a suicide would not have occurred would be unconstitutional.[273] The LPS should also require psychiatrists to assess the severity of the potential attempt, such as assessing the individual's access to lethal means and any previous attempts with highly lethal means. Because highly suicidal individuals without access to lethal means are less likely to die by suicide, committing them would be an unjustified violation of fundamental rights.[274] On the other hand, individuals who have made a past attempt with highly lethal means are at a higher risk of death even if they are not as strongly suicidal.[275]

d. Therapeutic Appropriateness

Before committing a suicidal individual under a Section 5250 or Section 5250 hold, the psychiatrist should also have to thoroughly assess whether the individual will even benefit from the hospitalization. Mere deterrence or even postponement of suicide is not enough justification, otherwise, the LPS may as well regress to permitting indefinite commitments.[276] Treatments for suicidality can include medication, cognitive behavioral

270. Such a definition will tie in closely with the definition of danger. *See* discussion *infra* Part VI.A.1.c.

271. *See* Lenell, *supra* note 126, at 746 (listing the inherent 4 components of danger for involuntary commitments).

272. CAL. WELF. & INST. CODE §§ 5250, 5260.

273. *See* discussion *supra* Part IV.E.

274. *See* HARV. SCH. PUB. HEALTH, *supra* note 273.

275. A study found that individuals who had a previous attempt with highly lethal methods were 7.8 times more likely to make attempt suicide again using another highly lethal method. Sang Hoon Oh et al., *Factors Associated with Choice of High Lethality Methods in Suicide Attempters: A Cross-Sectional Study*, 8 INT'L J. MENTAL HEALTH SYS. 4 (2014).

276. *See Crane*, 534 U.S. at 412 (implying that involuntary commitments are not appropriate for mere deterrence of dangerous acts); *see also* Lenell, *supra* note 126, 753 ("There is no evidence that detention and hospitalization will prevent a suicidal act.").

therapy, and dialectical behavioral therapy.[277] Psychiatrists should be required to show that not only can the psychiatric facility offer effective treatment methods, but they should also have to show that they and their staff are trained to use these methods specifically to treat suicidality.[278] Importantly, psychiatrists should not rely upon the underlying mental illness to justify their reasoning because the purpose of the involuntary commitment is to prevent suicide, not treat the broader symptoms of a mental illness. Additionally, since patients can still refuse treatment while inpatient, including medications, psychiatrists should also have to show evidence that even begrudging participation in therapy would be beneficial for the patient's suicidality.[279]

e. Less Restrictive Options

For the LPS to be constitutional, the involuntary commitment of suicidal individuals must be the least restrictive option for treating the individual's suicidality.[280] Because evidence shows that non-inpatient treatments are far more effective, psychiatrists should have to demonstrate that a less restrictive level of care will not suffice for their patient.[281] This showing should not include a need for 24-hour surveillance to prevent suicide because surveillance is a mere prevention of suicide, and, as mentioned above, does not justify complete deprivation of bodily liberty.[282] Thus, a psychiatrist should be required to show that the hospital's treatment method (such as duration, intensity, and frequency) is not something that any other treatment program is designed to offer.[283] The following table is a comparison of sample inpatient treatment, PHPs, and IOPs from the UCLA Resnick Neuropsychiatric Hospital:

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277. *See, e.g.*, *Treatment for Suicide related Thoughts and Behaviors*, HEALTH.MIL, https://health.mil/Military-Health-Topics/Centers-of-Excellence/Psychological-Health-Center-of-Excellence/PHCoE-Clinician-Resources/Suicide-Risk/Treatment-for-Suicide-related-Thoughts-and-Behaviors (last visited Nov. 30, 2023).

278. *Jackson*, 406 U.S. at 738 (requiring that the "commitment bear some reasonable relation to the purpose for which the individual is committed."). There is already a similar requirement for 5260 holds, though it does not specify the treatment target suicidality. CAL. WELF. & INST. CODE § 5260(c).

279. CAL. WELF. & INST. CODE § 5325.2. Requiring a showing that the patient would participate at all should not be required since patients may change their mind, either to participate or refuse to, in the middle of an involuntary commitment.

280. This discussion only addresses direct treatment of the suicidal individual, not the least restrictive means for preventing suicide through other public health measures discussed in *supra* Part IV.F.

281. STEFAN, *supra* note 2, at 120.

282. *See supra* note 276 and accompanying text.

283. *See supra* notes 193–97 and accompanying text for a description of treatments offered in PHP's and IOP's.

	Inpatient[284]	**PHP**[285]	**IOP**[286]
Program Span (days)[287]	31 days	28 days	28 days
Program Span (wks.)	4.43 wks.	4 wks.	4 wks.
Program Span (hrs.)[288]	744 hrs.	672 hrs.	672 hrs.
Weekly Treatment (hrs./wk.)[289]	30 hrs./wk.	22 hrs./wk.	10 hrs./wk.
Total Treatment (hrs.)	132.86 hrs.	88 hrs.	40 hrs.
Weekly Confinement (hrs./wk.)[290]	168 hrs./wk.	27 hrs./wk.	11 hrs./wk.
Total Confinement (hrs.)	744 hrs.	108 hrs.	44 hrs.
% of Total Treatment over Program Span[291]	17.86%	13.10%	5.95%
% of Total Confinement over Program Span[292]	100.00%	16.07%	6.55%
% of Total Treatment over Total Confinement[293]	17.86%	81.48%	90.91%

As the table shows, an inpatient individual spends 82.14% of his or her time deprived of liberty without the benefit of any kind of treatment. Instead, the patient must entertain themselves with what limited options are within the four walls of the psychiatric facility. Even though there are more hours

284. UCLA HEALTH, *UCLA Resnick Neuropsychiatric Hospital – 4 East A Unit Adult Inpatient Schedule*, https://www.uclahealth.org/sites/default/files/documents/3d/4-east-unit.pdf?f=d7ad423e (last visited Dec. 3, 2023).

285. UCLA HEALTH, *Adult PHP*, *supra* note 195.

286. UCLA HEALTH, *Adult IOP*, *supra* note 197.

287. This assumes the maximum possible days inpatient under the LPS (thirty-one total) and the upper end of treatment time for PHPs and IOPs at UCLA.

288. This is not the number of hours spent in the program but rather the total number of hours in the time from start to end of the treatment program.

289. This does not include the lunch hour. The PHP has an hour of lunch each day for five days, and the IOP only has lunch one day of the week.

290. This refers to the amount of time that patients are not free to do whatever they want, which would include the entire time they spend in the program, regardless of whether they are participating in treatment.

291. This is total amount of treatment time a patient gets compared to the total amount of time in the patient's life during the length of the program.

292. This is the total amount of time that the patient is not free to do whatever he or she wants compared to the total amount of time in the patient's life during the length of the program.

293. This is the amount of time the patient receives treatment compared to the amount of time that the patient is deprived of liberty to do what he or she wants.

of treatment per week in a psychiatric hospital than in a PHP or an IOP, the increase is nowhere near enough to compensate for the total time of liberty deprivation—particularly considering that PHPs and IOPs proportionately offer about four to five times the amount of freedom than inpatient stays do. A psychiatrist should have to justify why so little time in confinement dedicated to treatment will still be more beneficial than treatment in a PHP or IOP. If an inpatient stay is supposed to be intensive, the proportion of time in treatment should resemble those in less intensive programs. All three of these examples typically involve the same types of therapy and topics, so it does not appear that the treatment offered is different enough to warrant violations of fundamental rights.[294] However, the psychiatrist could show that, for the individual being committed, the hospital will provide significantly more time for treatment, or a very specific type of therapy not offered in a PHP or IOP. In such a case, the psychiatrist would be closer to proving that no less restrictive option exists for the individual.

2. Adversarial Hearings

Despite the important liberties at stake, suicidal individuals are offered no more than simple formalities in court to determine their fate.[295] The psychiatrist's sole and subjective determination is completely unchecked;[296] and the patient, usually assumed to be incompetent, is hardly in a position to successfully defend themselves.[297] The LPS should add three requirements to involuntary commitments of suicidal patients: 1) a neutral third-party psychiatrist's assessment, 2) friend or family input, and 3) proof of the patient's treatment preferences before the initial commitment. If neither of the last two are available, psychiatrists should have to show that they made a reasonable effort to meet those requirements.

In the aforementioned Harvard study involving two groups of doctors forensically diagnosing mental illnesses in suicide victims, those who were not aware that the individual had died by suicide had a much lower diagnosis rate.[298] Similarly, the LPS should require that another psychiatrist assess the suicidal patient's history and condition to determine whether a mental illness exists and whether the individual's background is indicative of dangerous behavior. To keep decisions neutral and fair, the third-party psychiatrist should not have access to the following: the patient, what LPS holds the hearing is for (first 14-day commitment or commitments after that), what led to the initial Section 5150 detention, the patient's behavior after the initial

294. *See* sources cited *supra* notes 195–97.

295. *See* discussion *supra* Part IV.D.

296. *See* Hart, *supra* note 66, at 125–27; Warren, *supra* note 6, at 630–31.

297. *See* discussion *supra* Part II.D.

298. *See* STEFAN, *supra* note 2, at 102.

detention, and what category the patient is in (danger to others, suicidal, or gravely disabled). Patients and their behavior can have a marked downturn in a psychiatric facility and may not be representative of their true state of mind, and any determinations made by the committing psychiatrist are colored by his or her personal feelings. Allowing the third-party psychiatrist access only to information on the patient before the behavior that led to the Section 5150 hold will better help ensure that the decision is not tainted by confirmation bias.

Second, when possible, the LPS should require that a friend or family member offer an opinion on whether the patient should be involuntarily committed. The psychiatrist usually does not know the patient very well, and what little knowledge the psychiatrist does have is from a very tumultuous time in the patient's life. Friends and family, on the other hand, have much greater knowledge of the suicidal individual and can better speak to whether an individual is behaving out of the ordinary or if the individual is chronically suicidal but unlikely to carry through with a successful attempt.[299] Further, friends and family usually have a much different motive from psychiatrists: they want to help the patient whether or not that means medical intervention, whereas psychiatrists are motivated to specifically treat a mental illness.[300]

Finally, prior evidence of how the suicidal individual wants to be treated in the event of a crisis should be heavily factored into the court's consideration. Because the suicidal individual, unfortunately, will likely be viewed as incompetent in court, evidence of treatment preferences before the time of commitment—from a time when the individual was considered competent—gives the patient a say in the hearing and can help decrease the feelings of coercion throughout the process.[301] For psychotic patients, Elyn Saks suggested that involuntary treatment be used only for the first time to allow psychiatrists to stabilize the patient enough to get the patient's treatment preferences.[302] Then those preferences can then be used for later episodes that may result in incompetence.[303] Similarly, outpatient providers should be required to ask for their patients' preferences for involuntary commitment at the start of their treatment plan, and the most recently stated preference should be used in an LPS involuntary commitment hearing (since patient may change their mind during the court of treatment).

299. *See* SAKS, *supra* note 116, at 56–57.

300. *Id.*

301. The MacArthur study on coercion showed that patients perceive less coercion, even in involuntary commitments, if they feel that their opinion was taken into consideration. WINICK, CIVIL COMMITMENT, *supra* note 7, at 25.

302. SAKS, *supra* note 116, at 59.

303. *Id.*

Without such precautions, suicidal individuals are deprived of the fully adversarial hearing that they are entitled to, and the required standards of proof that the Supreme Court has held to be required for individuals subjected to involuntary commitments are plainly ignored.[304]

3. Standard of Proof

The most flagrant violation of due process is the LPS's standard of proof required to involuntarily commit suicidal individuals under Section 5250 and Section 5250 holds.[305] The Supreme Court held in *Addington* that the standard of proof for involuntary commitments is "clear and convincing,"[306] and even the California Supreme Court held in *Roulet* that involuntary commitments require the same due process protections as criminal proceedings because the resulting consequences are so severe.[307] Yet, not only does the LPS not require proof "beyond a reasonable doubt" as can be inferred from *Roulet*, but it also does not even require "clear and convincing" evidence; as such, the LPS currently allows psychiatrists to strip suicidal individuals of their fundamental rights with mere "probable cause."[308] Even more egregious than the initial "probable cause" threshold is that Section 5250 holds do not even require *any* type of hearing—and certainly no finding of probable cause—to commit a suicidal individual for an additional fourteen days after they have already been committed for the first seventeen days.[309] Simply because *Addington* involved an indefinite commitment and the LPS has a 31-day limit does not permit California to flout the Supreme Court's ruling; the Court never limited its holding to only commitments of indefinite duration. Until such a time that the Supreme Court says otherwise, the LPS violates due process and the Supremacy Clause.

To comply with due process, the LPS must first require a hearing at the Section 5250 stage, not just at the Section 5250 stage. It is appalling to require less protection the longer a fundamental right is deprived. Second, the standard of proof must be raised to at least a "clear and convincing" standard during both of these hearings.[310] Since the psychiatrist will have known the patient for longer by the time of the Section 5250 hearing, it may even be appropriate to require "clear and convincing" evidence at a Section 5250

304. *Salerno*, 481 U.S. at 751; Hart, *supra* note 66, at 135.

305. *See* discussion *supra* Part IV.A.

306. 441 U.S. at 428.

307. 590 P.2d at 11.

308. CAL. WELF. & INST. CODE § 5256(a).

309. *See* source cited *supra* note 77.

310. Since involuntary commitments are state laws and the *Roulet* holding does not conflict with *Addington* under the Supremacy Clause, it may even be more appropriate for the LPS to follow the holding in *Roulet* and require proof "beyond a reasonable doubt."

hearing and proof "beyond a reasonable doubt" at a Section 5250 hearing. Either way, the LPS must raise its standard of proof, both to comply with legal precedent and to avoid the "unimpeachable" psychiatrist phenomenon.

4. Limit on Frequency

Finally, the LPS needs to have a limit on the number of times a suicidal individual can be involuntarily committed. Because one of the LPS's purposes was to limit indefinite involuntary commitments,[311] it should institute safeguards to prevent psychiatrists from using unlimited commitments in perpetuity. For example, the LPS could specify that suicidal patients cannot be detained on Section 5150 holds more than once a month, Section 5250 holds more than twice a year, and Section 5250 holds more than once a year. Otherwise, suicidal patients could be repeatedly committed under Section 5150, Section 5250, and Section 5250 holds after each 31-day inpatient stay, which would function no differently from indefinite involuntary commitments.

B. Removing Suicidal Individuals from the Statutes

However, even with the proposed modifications, the LPS would still pose an unconstitutional threat to suicidal individual's fundamental rights. The biggest issue is that currently there is still no way to reliably predict a successful suicide attempt.[312] The LPS should be narrowly tailored to prevent death by suicide, not to prevent mere attempts to hurt oneself, no matter how serious those injuries may be. Second, California has many other environmental measures it could take, such as adding barriers to the Golden Gate Bridge, which could more effectively reduce suicide attempts.[313] Before there is a method to predict the danger of suicide, and evidence establishing a continued need for involuntary commitments even after the removal of patient access to lethal methods, the LPS should not have suicidal individuals under its purview.

Further, voluntary treatments have consistently shown to be far more effective, for both the patient and the provider.[314] Even if a suicidal individual still ends up in a psychiatric hospital, if they choose to enter willingly, the effect of their admission is likely to be far more effective because the patient would be self-motivated to improve their situation.[315] Removing the

311. CAL. WELF. & INST. CODE § 5001 (legislative intent includes the purpose of "end[ing] the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders").

312. *See* discussion *supra* Part IV.C.2.

313. *See* discussion *supra* Part IV.F.

314. STEFAN, *supra* note 2, at 97; WINICK, CIVIL COMMITMENT, *supra* note 7, at 27.

315. *See* WINICK, CIVIL COMMITMENT, *supra* note 7, at 34, 166; WINICK, THE RIGHT TO REFUSE, *supra* note 26, at 331.

possibility of involuntary commitments will also make it easier for suicidal patients currently in treatment to trust their providers[316] and reduce a common barrier to treatment for many other people struggling with suicidality and mental illnesses.[317] Further, the change would also help providers provide more targeted care by reducing the fear of litigation since because they cannot be held legally liable for not taking a measure to prevent suicide if that measure was not available to them.[318]

In no way does this note aim to argue that suicide should not be addressed. Instead, it argues that current laws such as the LPS are simply not fixing this problem—in fact, it risks exacerbating it. If suicide is treated as an illness rather than a transgression, approached with compassion rather than contempt, then involuntary commitments should fade away.[319] The mere chance of protecting one fundamental freedom, "life," does not trump the guaranteed complete deprivation of another. Otherwise, Patrick Henry would never have uttered his famous words, "Give me liberty, or give me death!"[320]

VII. CONCLUSION

As the LPS currently stands, suicidal individuals seeking help may be subjected to punitive measures with fewer due process rights than a common criminal. Competence is supposed to be presumed, and incompetency is a prerequisite for California to involuntarily commit suicidal individuals. Yet the current LPS framework completely ignores these elements and instead suggests that diagnosed incompetency is *not* required to deprive a suicidal individual of freedom for an entire month. The ambiguous definitions and standards in the LPS allow psychiatrists to involuntarily commit almost anyone they want, whether or not the person is in imminent danger of suicide, thus failing to be narrowly tailored under strict scrutiny. Even worse, involuntary commitments can substantially damage an individual's mental state, increasing the danger of harm even for those who may not have been dangerously suicidal to begin with. Yet even though current LPS measures would not further California's interest in preventing suicide, the state will not redirect its focus to reducing access to lethal methods in the environment

316. *See* WINICK, CIVIL COMMITMENT, *supra* note 7, at 32–33; WINICK, THE RIGHT TO REFUSE, *supra* note 26, at 338.

317. *See* discussion *supra* Part IV.C.2.

318. *See* STEFAN, *supra* note 2, at 276; *see also supra* notes 184–89 and accompanying text.

319. *Contra* Les Dunseith, *Study Finds Involuntary Psychiatric Detentions on the Rise*, UCLA NEWSROOM (Nov. 3, 2020), https://newsroom.ucla.edu/releases/involuntary-psychiatric-detentions-on-the-rise (finding that involuntary commitments are drastically increasing in proportion to population growth).

320. WILLIAM WIRT, SKETCHES OF THE LIFE AND CHARACTER OF PATRICK HENRY 123 (Applewood Books 2009) (1817).

or enact regulations that would be far more likely to reduce suicide without infringing on fundamental rights. This casts doubt on whether California is honestly interested in diminishing suicide rates, or if the state is simply using the LPS as a way to punish unfavorable behavior. This note argues that given the current state of psychiatric research, suicidal individuals should not be subjected to the LPS, or other involuntary commitment laws that deprive them of fundamental rights, in the name of "treatment." In the alternative, this note urges California to modify the existing LPS provisions regarding suicidal individuals to offer them at least minimal due process before stripping them of their autonomy and liberty. Given the potential future developments of the DSM-V, it is imperative that the LPS provide narrowly tailored guidelines to protect suicidal individuals from constitutional violations. As other states continue to model their laws after the LPS, such modifications are needed before the other states continue to perpetuate unconstitutional restraints on those suffering from suicidality.

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