



Lanterman-Petris-Short Act

California Has Not Ensured That Individuals
With Serious Mental Illnesses Receive Adequate
Ongoing Care

July 2020

REPORT 2019-119





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July 28, 2020
2019-119

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As directed by the Joint Legislative Audit Committee, my office conducted an audit of the implementation of the Lanterman-Petris-Short Act (LPS Act) in Los Angeles County, San Francisco County, and Shasta County. The LPS Act permits involuntary mental health treatment when, because of mental illness, individuals pose a risk of harm to themselves or others or cannot provide for their basic needs. We conclude that the LPS Act's criteria for involuntary treatment allows counties sufficient authority to provide short-term involuntary treatment to people. Expanding the LPS Act's criteria to include additional situations in which individuals may be involuntarily treated could potentially infringe upon people's liberties—and we found no evidence to justify such a change. Nonetheless, California has not ensured adequate care for individuals with serious mental illnesses in its broader mental health care system.

Perhaps most troublingly, many individuals were subjected to repeated instances of involuntary treatment without being connected to ongoing care that could help them live safely in their communities. For example, almost 7,400 people in Los Angeles County experienced five or more short-term involuntary holds from fiscal years 2015–16 through 2017–18, but only 9 percent were enrolled in the most intensive and comprehensive community-based services available in fiscal year 2018–19. Also, counties in California have not widely adopted assisted outpatient treatment—a community-based approach to mental health treatment that could help prevent involuntary treatment in institutional settings. Assisted outpatient treatment is an effective approach to serving individuals in their communities, and we make recommendations to expand access to this treatment.

Because the State's current public reporting related to mental health services relies on disjointed and incomplete tools, policymakers and other stakeholders do not have the information they need to assess the effect of the billions of dollars California invests in its mental health system each year. An overhaul of mental health reporting requirements is necessary to bring greater accountability to this system. In the interim, immediate changes to state law could direct Mental Health Services Act funds toward people leaving involuntary treatment to ensure that they receive effective, community-based care.

Respectfully submitted,

A handwritten signature in black ink that reads "Elaine M. Howle". The signature is written in a cursive, flowing style.

ELAINE M. HOWLE, CPA
California State Auditor

Selected Abbreviations Used in This Report

CalMHSA	California Mental Health Services Authority
LPS	Lanterman-Petris-Short
MHSA	Mental Health Services Act

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Summary

Results in Brief

Millions of Californians experience mental illnesses, including nearly two million who experience mental, behavioral, or emotional disorders that substantially interfere with major life activities (serious mental illnesses). The consequences of these illnesses can be dire: for instance, people with serious mental illnesses are at increased risk of early mortality and experience significant rates of incarceration and homelessness. Treatment can help people cope with the symptoms they experience; however, individuals with serious mental illnesses may not always seek or receive treatment voluntarily, and as a result, they can sometimes pose a risk of harm to themselves or others. To address these risks and to reduce the use of restrictive, institutional mental health care, the Legislature passed the Lanterman-Petris-Short Act (LPS Act) in 1967. The LPS Act allows qualified treatment facility staff or other county-designated professionals (designated professionals) to provide involuntary mental health treatment to people who, because of a mental illness, are a danger to themselves or others, or cannot provide for their basic personal needs of food, clothing, or shelter. Specifically, the LPS Act establishes three main stages during which people can be treated involuntarily: short-term holds of up to 72 hours, extended holds that generally last up to 14 days, and conservatorships of up to one year during which courts appoint outside parties, such as county officials, to assume responsibility for individuals' care. This audit focuses on the implementation of the LPS Act in three counties—Los Angeles County (Los Angeles), San Francisco County (San Francisco), and Shasta County (Shasta)—and how the act functions within those counties' broader mental health systems.

Some organizations have expressed concerns that the criteria in the LPS Act for involuntary treatment are inadequately defined and that counties have inconsistently applied those criteria, preventing some individuals from receiving necessary involuntary treatment. However, based on our review of 60 short-term involuntary holds and 60 conservatorship cases in the three counties we examined, we found that the LPS Act's criteria appropriately enabled the designated professionals and courts to place people who needed involuntary treatment on LPS Act holds or conservatorships. Further, the designated professionals in the three counties generally interpreted and applied LPS Act criteria similarly when making decisions about involuntary treatment. Expanding the LPS Act's criteria to add more situations in which individuals would be subject to involuntary holds and conservatorships could widen their use and potentially infringe upon people's liberties, and we found no evidence to justify such a change.

Audit Highlights . . .

Our audit of the implementation of the LPS Act in three counties, highlighted the following:

- » *The LPS Act's criteria for involuntary mental health treatment allows counties sufficient authority to provide short-term involuntary treatment to people who needed it, and we found no evidence to justify any changes to the criteria.*
- » *Although the LPS Act's criteria are sufficient for involuntary holds and conservatorships, we found significant issues with how Californians with serious mental illnesses are cared for.*
 - *Individuals on conservatorships have limited treatment options—many could not receive specialized care in state hospital facilities for an average of one year because of a shortage of available treatment beds.*
 - *Individuals exiting involuntary holds have not been enrolled consistently in subsequent care to help them live safely in their communities—in two counties, no more than 9 percent of these individuals were connected to ongoing care.*
 - *Less than one-third of the State's counties—only 19—have adopted assisted outpatient treatment, even though it is an effective community-based approach to mental health treatment to help prevent future involuntary holds and conservatorships.*

continued on next page . . .

» *Despite the billions of dollars the State invests in the county-based mental health system each year, stakeholders do not have the information they need to assess the effectiveness of these funds on people's lives.*

- *Public reporting of dedicated funds is disjointed and incomplete.*
- *Current Mental Health Services Act reporting requirements make it difficult to assess the balance of counties' unspent funds.*

» *Mental health reporting requirements should be overhauled to capture comprehensive spending information as well as outcomes for programs.*

However, just because the LPS Act's criteria for involuntary holds and conservatorships are sufficient to meet the intent of the Act does not mean the State is adequately caring for Californians with serious mental illnesses, and we identified other significant issues related to that care that we believe warrant action. For example, when we looked at the availability of treatment options for individuals on conservatorships, we found that people who were on the waitlist for specialized care in state hospital facilities had been waiting an average of one year to receive that care because of a shortage of available treatment beds. While they waited, some of the individuals received other care that did not fully meet their needs and did not fully protect them or others around them. Similarly, at the county level, Los Angeles and Shasta reported that they have a shortage of available treatment beds for a variety of types of care. However, only Los Angeles showed a robust understanding of its current capacity and need for additional treatment beds. Neither Shasta nor San Francisco has taken the steps necessary to ensure that they fully understand their needs for additional resources.

Additionally, in Los Angeles and San Francisco individuals exiting involuntary holds have not been enrolled consistently in subsequent care that could help them live safely in their communities. Specifically, of almost 7,400 people in Los Angeles who each had been placed on five or more short-term holds from fiscal years 2015–16 through 2017–18, only 9 percent were enrolled during fiscal year 2018–19 in full-service partnerships or assisted outpatient treatment—the most comprehensive and intensive methods available to all counties for providing community-based care to individuals with serious mental illnesses. In San Francisco, the proportion was even lower. The LPS Act is intended to stabilize individuals who are experiencing crises because of their mental illnesses. Thus, people leaving LPS Act holds often need continuing mental health services; in particular, individuals who have experienced several short-term holds represent a high-need population that should be connected to counties' most intensive community-based care. However, Los Angeles and San Francisco did not always identify individuals who had been on multiple short-term holds or ensure that these individuals received the ongoing care they needed. One reason for this gap in care is that counties do not have access to confidential state-managed data about the specific individuals who have been placed on holds in the past.

Moreover, fewer than a third of California's counties have adopted assisted outpatient treatment, even though it is an effective treatment option that could help prevent individuals from cycling through involuntary holds and conservatorships. Assisted outpatient treatment allows individuals to remain in

their communities while still receiving the critical care they need, either voluntarily or by court order, depending on their circumstances. Nonetheless, only 19 counties have adopted such programs since California authorized them in 2003. The eligibility criteria that state law establishes for assisted outpatient treatment are one barrier to wider use of this treatment approach. For example, the criteria effectively exclude those leaving or recently on conservatorships from participating in this program. However, about one in four individuals placed on conservatorships whose cases we reviewed cycled back to restrictive settings, despite having successfully recovered their abilities to provide for basic needs at the time their conservatorships ended. In other words, a population of individuals who would likely benefit from assisted outpatient treatment are effectively ineligible to receive that continuing treatment. Further, with respect to involuntary assisted outpatient treatment, state law does not explicitly allow courts to order medication in an individual's treatment plan despite the importance of medication to some individuals' ability to live independently. Addressing these issues by changing the law would allow counties to better care for people with serious mental illnesses.

The treatment that individuals receive through the LPS Act is only one part of a much larger, county-based mental health system in which California invests billions of dollars each year. Despite the magnitude of that investment, policymakers and other stakeholders do not have the information they need to understand the extent to which these funds affect people's lives. The State's current public reporting related to mental health programs and services relies on disjointed and incomplete tools—a result of multiple funding sources with different requirements and levels of transparency. For instance, we did not identify consistent public reporting of funds that the State distributed when it transferred its responsibilities for providing mental health services to counties—which totaled nearly \$3 billion in fiscal year 2018–19—or to the outcomes counties produce for individuals with serious mental illnesses through those services. The Mental Health Services Act (MHSA) contains the most comprehensive public reporting requirements of the major mental health funding sources, but this reporting is still insufficient for understanding the full range of counties' mental health spending. Further, current MHSA reporting requirements make it difficult for stakeholders to assess the balances of counties' unspent funds.

Given these issues, an overhaul of mental health reporting requirements is necessary. We outline in this report a possible framework for this overhaul that includes capturing comprehensive spending information as well as outcomes for counties' specific programs and for the State's overarching mental health system.

Because it already oversees MHSA reporting—the reporting closest to our proposed model—the Mental Health Services Oversight and Accountability Commission (Oversight Commission) is best suited to oversee a new approach to reporting on spending and outcomes. Without such a framework for consolidating information about the full range of mental health services, the State will remain unable to fully understand the impact of its mental health investments and the changes it could make to better serve those coping with mental illnesses. Further, we identified immediate changes the Legislature should make to direct MHSA funds toward people leaving LPS Act holds to ensure that they receive effective, community-based care.

Summary of Recommendations

Legislature

The Legislature should amend state law to do the following:

- Adjust reporting requirements for LPS Act holds to ensure that counties can access existing state-managed data about the specific individuals placed on holds.
- Require the Department of State Hospitals to report the costs of increasing state hospital facility capacity to care for individuals treated under the LPS Act.
- Require counties to adopt assisted outpatient treatment programs. Further, the Legislature should explicitly allow for medication requirements as a part of court-ordered assisted outpatient treatment and change the eligibility requirements for assisted outpatient treatment programs so that they do not exclude individuals who have recently left conservatorships.
- Assign the Oversight Commission primary responsibility for developing, implementing, and overseeing a comprehensive framework for reporting mental health spending across all major fund sources, as well as program-specific and statewide mental health outcomes.
- Direct counties to spend MHSA funds for the purpose of connecting individuals leaving LPS Act holds or conservatorships to community-based services.

San Francisco and Shasta

By August 2021, San Francisco and Shasta should conduct assessments to determine the number and type of treatment beds that they need to provide adequate care to individuals receiving involuntary treatment. Once the assessments are complete, the counties should adopt plans to develop the needed capacity.

Los Angeles and San Francisco

By August 2021, Los Angeles and San Francisco should adopt systematic approaches to identifying individuals placed on multiple involuntary holds in their county-designated facilities, obtaining information about those individuals, and connecting them to services that support their ongoing mental health.

Agency Comments

Los Angeles and San Francisco both disagreed with our conclusion that the LPS Act's involuntary hold criteria are sufficient. Both counties agreed with our recommendation to provide counties access to information about LPS Act holds. Los Angeles expressed strong disagreement with our recommendations related to mental health care spending and outcome tracking, while San Francisco agreed with those recommendations. Shasta chose not to respond to our report.

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Introduction

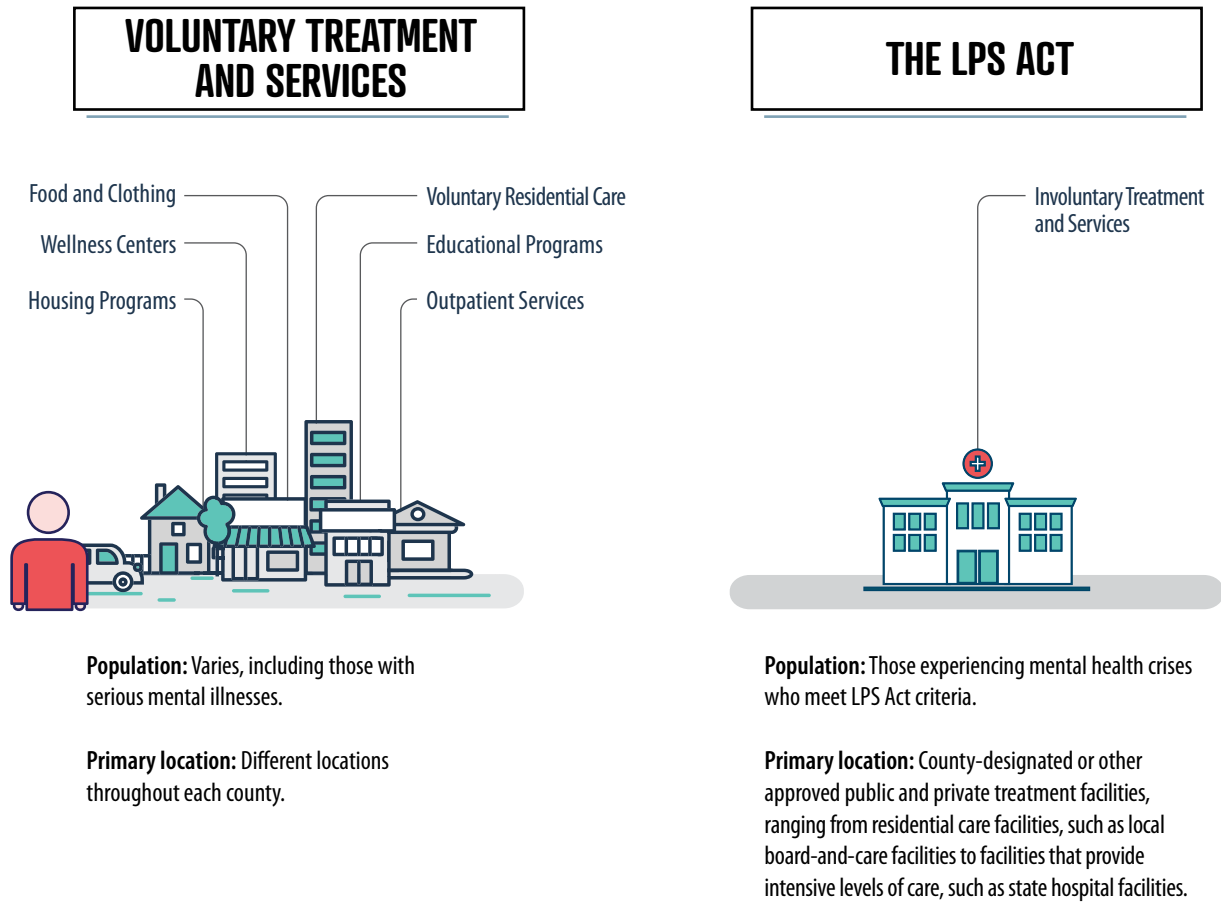
Background

According to federal and state data, millions of Californians experience mental illnesses, including nearly two million individuals who experience one or more mental, behavioral, or emotional disorders that substantially interfere with major life activities (serious mental illnesses).¹ Serious mental illnesses can include schizophrenia, post-traumatic stress disorder, bipolar disorder, and severe major depression. The consequences of these illnesses can be dire: individuals with serious mental illnesses have shorter life expectancies than the general population and experience significant rates of incarceration and homelessness. Treatment can help people cope with the symptoms of serious mental illnesses, which can include hallucinations, delusions, and disorganized thinking; for example, medication and psychotherapy can help individuals manage those symptoms. However, without treatment, people with serious mental illnesses can sometimes pose a risk of harm to themselves or to others.

California has a largely county-based system for providing mental health care to those living with mental illnesses, including serious mental illnesses. In general, counties' public mental health systems have both involuntary and voluntary components, as we illustrate in Figure 1. The Lanterman-Petris-Short Act (LPS Act), which the Legislature added to state law in 1967, generally governs the involuntary treatment components. Specifically, it outlines the circumstances under which county-designated treatment facilities (treatment facilities) can hold people involuntarily in order to provide mental health evaluation and treatment, as we discuss in more detail below. This report focuses on people treated under the LPS Act in three counties—Los Angeles County (Los Angeles), San Francisco County (San Francisco), and Shasta County (Shasta)—as well as the services available to those individuals and others within the counties' broader mental health systems.

¹ For the purposes of this report, we define *serious mental illnesses* to include serious mental illnesses in adults as well as serious emotional disturbances in children. We use the term *mental illness* to encompass *mental disorder* and other similar terms used in state law.

Figure 1
The LPS Act Governs Only One Part of Counties’ Broader Mental Health Systems

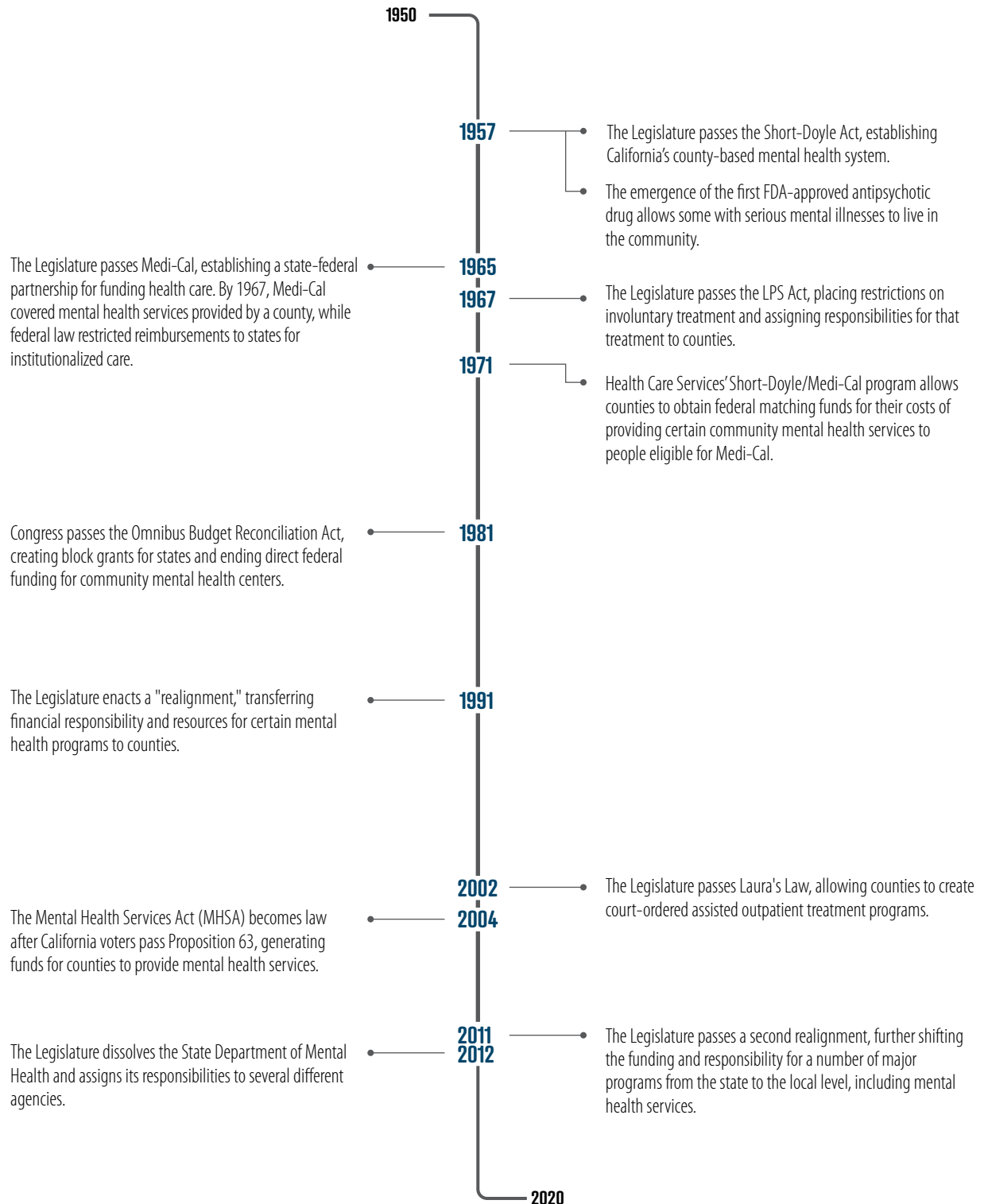


Source: State law, regulations, and analysis of documents detailing the treatment and services available in the three counties we reviewed.

The State’s Approach to Serving Individuals With Serious Mental Illnesses Has Changed Over Time

The Legislature passed the LPS Act amid a broader effort to deinstitutionalize mental health care, as we show in Figure 2. Over the past several decades, the federal government and California have taken steps to limit involuntary and institutional mental health treatment and to assign responsibilities for mental health treatment to counties. The LPS Act was an important part of these changes; it placed certain restrictions on involuntary treatment and assigned responsibilities for involuntary treatment to California’s counties. According to a report from the federal Substance Abuse and Mental Health Services Administration, the LPS Act also served as a model for other states that revised their own involuntary commitment laws.

Figure 2
California’s Approach to Mental Health Treatment Has Changed Over Time



Source: State and federal law, state agency reports, and congressional reports.

Roles and Responsibilities of Key State Agencies Involved in Mental Health Care

- Department of Health Care Services
 - Collect and publish statistics related to LPS Act holds and conservatorships.
 - Enact regulations related to aspects of community mental health care.
 - Manage Medi-Cal mental health coverage and services.
 - Perform compliance reviews of programs funded under the Mental Health Services Act (MHSA).
 - Approve county treatment facilities for LPS Act holds.
 - License certain mental health treatment facilities.
- Department of State Hospitals
 - Oversee and operate state hospital facilities that provide treatment to individuals with serious mental illnesses, including those held under the LPS Act.
- Mental Health Services Oversight and Accountability Commission
 - Oversee implementation of the MHSA.
 - Provide training and technical assistance for county mental health planning.
 - Evaluate counties' uses of MHSA funding.
 - Approve funding for counties' MHSA Innovation programs.

Source: Analysis of state law, state agencies' policies and procedures, and information from state agencies' websites.

As the State has increasingly moved toward a county-based system for providing mental health care, its own role in administering and overseeing such care has changed. For instance, California has closed several of its state hospital facilities, which generally provide intensive treatment in locked settings for those with serious mental illnesses. As a result, the number of people treated in state hospital facilities has declined significantly; although state hospital facilities treated more than 37,000 individuals in 1959, they were treating only slightly more than 6,000 individuals in November 2019. Further, the State dissolved its Department of Mental Health in 2012 and assigned its responsibilities to several different agencies, some of which we list in the text box. Currently, these agencies hold the primary oversight responsibilities for the State's public mental health system.

The LPS Act Permits Involuntary Treatment for People Experiencing a Mental Health Crisis

In certain circumstances, involuntary mental health treatment is necessary to stabilize people and prevent harm. In some cases, people with serious mental illnesses experience symptoms that cause them to lack insight into their illnesses. In other words, they may not be able to recognize or acknowledge that they have a mental illness or its extent. Individuals with these symptoms may not voluntarily seek treatment, and involuntary treatment may be the only way they receive care. To provide involuntary

treatment under the LPS Act, qualified treatment facility staff or other county-designated professionals (designated professionals) generally must determine that the individuals meet specified criteria: that as a result of mental illness, they are dangerous to themselves, dangerous to others, or gravely disabled—meaning that they are unable to provide for their basic personal needs for food, clothing, or shelter.²

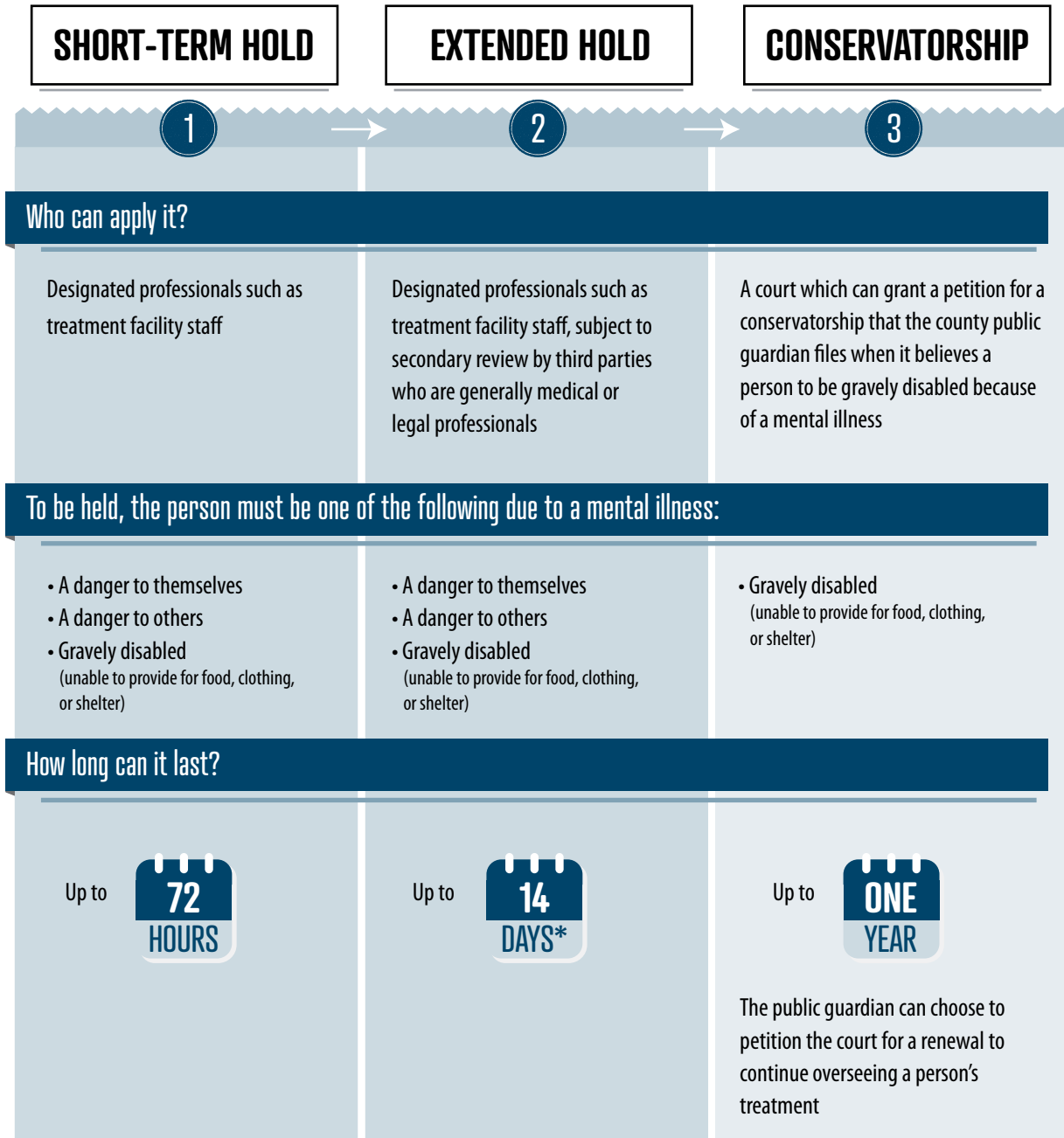
² The LPS Act also permits designated professionals to provide involuntary treatment to individuals who meet these criteria because of substance abuse or chronic alcoholism. Because the cases we reviewed almost exclusively identified individuals' mental illnesses as the reasons they met the LPS Act criteria, we focus our report on those aspects of the LPS Act.

Because the stated legislative intent of the LPS Act is to end the inappropriate, indefinite, and involuntary commitment of people with mental illness, it includes several protections of the rights of those subject to such treatment. The LPS Act generally establishes three stages of involuntary treatment, which we depict in Figure 3. These stages automatically expire and require those advocating for additional involuntary treatment—designated professionals or the county public guardian (public guardian), which is generally an agency designated by a county government to provide conservatorship services—to justify the need for further treatment. The LPS Act requires those providing treatment to assess whether they can properly serve individuals voluntarily before initiating involuntary treatment, and it also requires that treatment providers release individuals from involuntary holds if at any point they no longer need involuntary treatment. Further, the stated legislative intent of the LPS Act is for individuals to receive treatment in the least restrictive setting appropriate for their needs, and the LPS Act allows individuals to receive their involuntary care at a range of treatment facility types based on their needs, as we indicate in Figure 1.

The first type of LPS Act hold is the shortest—lasting no more than 72 hours—and the most common. Because these short-term holds are typically an individual's first encounter with LPS Act treatment, they represented a vast majority—nearly 80 percent—of the LPS Act holds that occurred in fiscal year 2018–19 in the three counties we reviewed. The LPS Act allows responders to bring individuals to county-designated treatment facilities for evaluation and treatment if the responders have probable cause to believe that the individuals meet the criteria for an involuntary short-term hold. These responders can receive alerts from the communities they serve about individuals potentially in need of care; for example, family members may contact the police for help when they are concerned about a relative's behavior. In our analysis, these responders were either from county behavioral health services or mobile crisis teams, law enforcement, or medical professionals. Once responders have brought individuals to a designated facility, designated professionals assess them to determine whether they will be held for up to 72 hours to receive treatment. Individuals placed on short-term holds must receive whatever treatment their conditions require, which may include medication. Designated professionals can end a short-term hold before the 72 hours have elapsed only if the treating psychiatrist determines that the person no longer requires evaluation and treatment under the hold.

Figure 3

The LPS Act Outlines a Process That Generally Involves Three Stages of Involuntary Treatment for Mental Illness



Source: Analysis of state law and the California Department of Justice's mental health holds data.

* The LPS Act also provides for other types of holds, such as extended holds of up to 30 days, an additional hold of 14 days for suicidal individuals, or an additional hold of up to 180 days for imminently dangerous individuals, and it grants individuals placed on such holds the right to judicial review of the holds. These were less common than the 14-day hold.

If, at the conclusion of a short-term hold, the designated professionals in a treatment facility believe a person continues to meet the requirements for evaluation and treatment, they can place the individual on an extended involuntary hold of up to 14 days. Unlike short-term holds, the LPS Act requires a legal review process for extended holds to ensure that continued involuntary treatment is justified. Specifically, the act requires that an official—generally a medical or legal professional, such as a court-appointed commissioner—conduct a hearing to review the extended hold within four days of when the treatment facility initiates the hold. The act also requires an attorney or patient advocate to meet with the patient to answer their questions and assist them in preparing for their hearing.

If the designated professionals believe that after an extended hold, the individual continues to be gravely disabled—that is, unable to provide for their basic personal needs and unwilling or incapable of accepting treatment voluntarily—the designated professionals can recommend that the public guardian begin proceedings to establish a conservatorship of up to one year.³ The decision to establish a conservatorship requires significantly more legal involvement than earlier stages of LPS Act involuntary treatment, and conservatorships are relatively rare compared to these other holds, as Appendix C details. Unlike the process for placing the two shorter holds, a public guardian must petition a superior court to establish a conservatorship following an investigation. The public guardian investigates the need for conservatorship and, if appropriate, assumes responsibility for the care of the individual placed on conservatorship. When the public guardian seeks a conservatorship, the individual—who is represented by a public defender or other court-appointed attorney—can either accept the conservatorship or contest it through a trial. The purpose of a conservatorship trial is to allow the contesting individual to offer evidence against establishing a conservatorship and challenge the testimony of doctors and others recommending conservatorship.

The LPS Act requires a high burden of proof in order to place someone on conservatorship. The county must prove the need for a conservatorship beyond a reasonable doubt—the same burden of proof as needed to convict someone in a criminal proceeding. This burden exists because courts have determined that conservatorship proceedings under the LPS Act threaten individual liberty and

³ The LPS Act includes another definition of *grave disability* that applies to people who have been found incompetent to stand trial on certain criminal charges and who represent a substantial physical danger to others as a result of mental illness. In this report, we focus on the definition of *grave disability* as the inability to provide for food, clothing, or shelter as a result of a mental illness, which was the definition applicable to the majority of the conservatorship cases we reviewed.

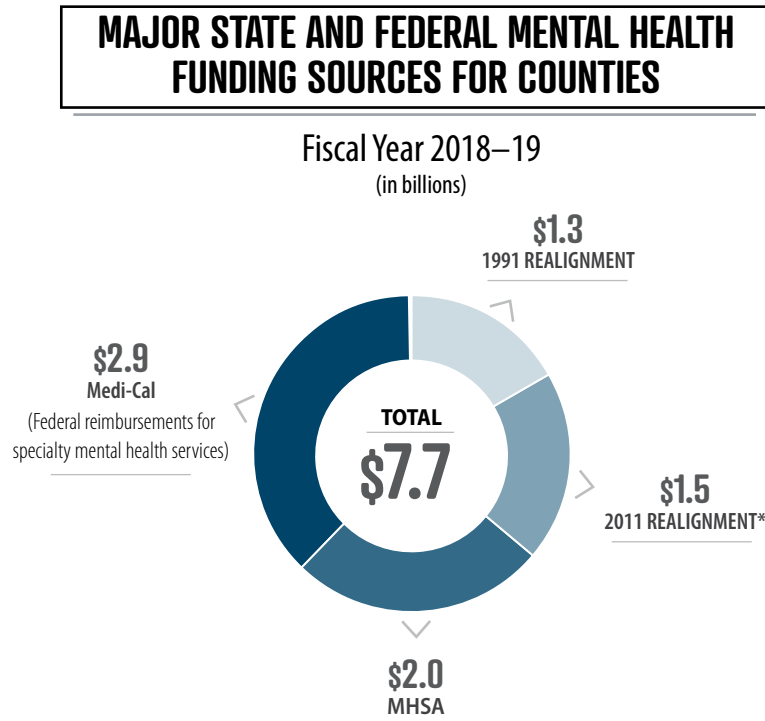
personal reputation no differently than the burdens associated with criminal prosecutions. People placed on a conservatorship can lose certain rights, including their right to refuse medication for their mental illnesses. Their court-appointed conservators—who can be public guardians but can also be suitable private parties, such as relatives of the people placed on conservatorship—are permitted to place them in treatment facilities and require them to receive treatment.

Finally, in addition to involuntary holds, the LPS Act allows counties to adopt assisted outpatient treatment programs, which provide intensive treatment services in community settings—such as psychological or psychiatric services coordinated by a personal case manager. Counties that establish assisted outpatient treatment programs can compel treatment using the court system if individuals are unlikely to survive safely without supervision, have histories of lack of compliance with treatment, and meet other criteria specified in the LPS Act. Counties with assisted outpatient treatment programs must also make these programs available for individuals to participate in voluntarily.

Counties Annually Receive Billions of Dollars in State and Federal Funding to Provide Mental Health Services

Counties received billions of dollars from state and federal sources to fund their mental health systems in fiscal year 2018–19, as Figure 4 details. The counties' single largest source of funding for mental health services is Medi-Cal, a state-run system through which the counties receive federal reimbursements for treatment they provide to eligible Californians. Medi-Cal is the State's version of Medicaid, and it covers a range of mental health services that include some crisis stabilization services, inpatient care, and residential treatment. Counties also receive state funds to manage certain mental health programs—such as inpatient care, community-based services, and services for youth—that the State realigned by transferring its responsibilities to counties in and around 1991 and 2011 (realignment funds). Counties generally have flexibility over their spending of realignment funds. Additionally, in 2004 California voters passed the Mental Health Services Act (MHSA), which funds certain county mental health services—mainly for those with serious mental illnesses—by levying an annual tax on the portions of people's taxable incomes that exceed \$1 million.

Figure 4
 Counties Receive Billions in State and Federal Funds That They Can Use to Support Their Mental Health Systems



Source: Estimates based on analysis of State Controller’s Office allocations to counties, the fiscal year 2019–20 State Budget, and information from Health Care Services.

Note: This figure does not include all public funding sources for mental health, such as certain federal grants and funds that support state-managed mental health services. However, we believe the funds depicted represent the vast majority of state and federal funding that supports counties’ mental health systems.

* Counties can also use these realignment funds for substance abuse programs and services.

Because the LPS Act encourages the full use of existing public funds to accomplish its objectives, counties generally fund their treatment and services associated with the LPS Act from the funding sources in Figure 4 as well as from local funds. However, restrictions prevent counties from using certain funds for those purposes. For example, state regulations establish that MHSA funds cannot pay for long-term hospital or institutional care, which limits counties’ ability to use those funds to provide such care under the LPS Act. Nevertheless, counties can use any of the funding sources we depict in Figure 4 to fund voluntary services that may benefit those treated under the LPS Act as well as others with mental illnesses.

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Chapter 1

THE STATE AND COUNTIES HAVE NOT ENSURED THAT INDIVIDUALS TREATED UNDER THE LPS ACT RECEIVE APPROPRIATE CARE

Chapter Summary

Designated professionals in California have sufficient authority and guidance under the LPS Act to place people experiencing a crisis because of their mental health conditions on involuntary holds or conservatorships and provide them with treatment. However, counties, state facilities, and the Los Angeles Superior Court have sometimes failed to provide adequate care and sufficient privacy safeguards to those who have received involuntary treatment. For example, insufficient state hospital resources have caused individuals needing a high level of care to wait an average of one year to receive care in a state facility. Further, the Los Angeles Superior Court has held public conservatorship proceedings that included discussions of individuals' confidential health information. Los Angeles and San Francisco also have high numbers of individuals who have been subject to multiple short-term holds but who have not received continuing care in their broader mental health systems. We believe that changes to state law are necessary to address treatment challenges and privacy concerns, given their profound potential ramifications for people with serious mental illnesses.

The LPS Act's Criteria Provide Sufficient Authority for the Use of Involuntary Holds or Conservatorships When Individuals Require Crisis Treatment

In the cases we reviewed, the LPS Act's criteria enabled first responders, designated professionals, and courts to place people who needed crisis treatment on involuntary holds or conservatorships. As the Introduction describes, the LPS Act allows designated professionals to place such individuals into short-term holds if, as the result of their mental disorders, those individuals are dangerous to themselves, dangerous to others, or gravely disabled—meaning they are unable to provide for basic personal needs. Further, for individuals who cannot provide for their basic needs, the LPS Act also allows for longer-term treatment through conservatorships, which we observed were typically sought by the public guardian. Each county we reviewed has guidance to help define these involuntary hold or conservatorship criteria. Our review of case files at each county included cases in which the county's first responders and designated professionals did not place people on involuntary holds. However, we did not definitively

identify any situations in which first responders and designated professionals failed to hold individuals when they might have met the standards in the counties' guidance for such measures. In one case we were unable to reach a definitive conclusion based on the documentation available. We also did not identify any situations in which individuals were involuntarily held when the holds were not justified under the county's standards.

Some organizations have raised concerns that designated professionals have inconsistently applied the involuntary hold criteria across the State, in part because the LPS Act does not define the criteria clearly enough. A wide disparity in the application of these criteria could lead to significant differences in the types of mental health care provided and who receives such care in different parts of the State. In other words, the level of service one received would depend on where one resided. Further, the director of Los Angeles's Department of Mental Health stated that the grave disability criterion—the only criterion for establishing a conservatorship under the LPS Act—does not adequately account for the range of threats someone can present to the public or to themselves and that he believed that California must have more systematic ways of determining whether someone can live safely in their community. However, we found that the designated professionals in the three counties we reviewed have generally interpreted and applied the LPS Act criteria similarly when making decisions about involuntary holds, and they have used definitions of grave disability that were not overly restrictive. Figure 5 provides examples of cases we reviewed in which designated professionals in the counties used the involuntary hold criteria to address substantively similar circumstances.

Although the LPS Act does not elaborate on what it means to be a danger to oneself or to others, the three counties generally defined these two criteria the same way.

Although the LPS Act does not elaborate on what it means to be a danger to oneself or to others, the three counties generally defined these two criteria the same way. Specifically, each county's guidance indicates that first responders should consider individuals a danger to themselves if, as a result of mental illness, they engage in behavior that would hurt themselves or they have the intent to hurt themselves. Staff at each county clarified that individuals who are suicidal and have plans to carry out those intentions meet the criterion of being a danger to themselves. San Francisco also noted that individuals do not necessarily need to have expressed suicidal thoughts to be considered a danger to themselves and that behaviors such as walking into traffic because of delusions would also meet this criterion. The counties' guidance defines being a danger to others similarly to being a danger to oneself. Each county's guidance states that someone is a danger to others if, as the result of a mental illness, their words or behaviors indicate that they would harm another person. According to the counties, individuals who express homicidal intent would meet this criterion.

Figure 5
Individuals Placed on Holds or Conservatorships in Each of the Three Counties Exhibited Similar Indications That They Had Met the LPS Act Criteria



Source: Analysis of information from our review of case files that we modified to protect the individuals' identities.

In the cases we reviewed, the designated professionals followed their counties' definitions when placing individuals on involuntary holds when they believed the individuals presented a danger to themselves or to others. Among the 60 short-term hold decisions we reviewed—which were split evenly among the three counties—we identified 51 cases in which the reasons for the hold included danger to self or others. In more than 85 percent of those cases, the records indicated that the individuals clearly met the standards of being either suicidal or homicidal with plans to carry out those intentions. In the remaining cases, the individuals were also

Designated professionals in all three counties followed consistent standards, when applying the grave disability criterion.

apparent dangers to themselves or others around them even though they were not clearly homicidal or suicidal. For example, one case involved an individual whose mental illness led them to consume foreign objects that could have killed them.⁴ In another case, an individual whose symptoms led to self-injurious behavior was unable to communicate clearly with first responders because of the severity of those symptoms.

Designated professionals in the counties also followed similar standards when applying the grave disability criterion. Shasta's guidance related to this criterion is more detailed than Los Angeles's and San Francisco's in that it provides examples of situations that would qualify a person as gravely disabled. However, designated professionals in all three counties applied consistent standards in the cases we reviewed. Specifically, in nine of the 60 short-term hold decisions we reviewed, the sole reason for the holds was that the individuals were gravely disabled. In these cases, the individuals were generally unable to articulate clear plans for their own care and were sometimes experiencing delusions. Our review of these cases, as well as a selection of 60 instances in which first responders decided not to place individuals on holds, indicates that the responders and designated professionals generally did not use overly narrow definitions of grave disability that left people who appeared unable to provide for their own basic needs without crisis care.

Our findings were similar when we reviewed 60 conservatorship cases, all of which involved individuals the courts had determined were gravely disabled. The records we reviewed included the county public guardians' investigation reports and supporting court documentation for the conservatorship appointment and termination. In the cases we reviewed, the judicial review process mandated by the LPS Act—in which a person cannot be placed on conservatorship without a hearing before a court to consider the necessity of the conservatorship—explicitly considered the individuals' rights by requiring proof of grave disability beyond a reasonable doubt while also considering the individuals' need for treatment. In these cases, public guardians and superior courts did not limit the use of conservatorship by, for example, requiring homelessness as proof of inability to provide shelter. Rather, we saw reasonable variations among the factors that demonstrated that individuals could not adequately provide for their own basic needs. In addition, the documentation demonstrated that each county's public guardian and superior court considered the level of insight these individuals had into their illnesses and their voluntary treatment history when determining whether conservatorships were necessary.

⁴ To protect the identities of the individuals we discuss in this report, we have chosen to use the pronoun *they* or *them* when presenting examples from our case reviews.

The stated intent of the Legislature in enacting the LPS Act was to provide for prompt evaluation and treatment, to protect the public, and to safeguard personal rights through consistent standards. Our review, which was limited to three counties and a selection of case files, leads us to conclude that the LPS Act's criteria are defined well enough to serve those purposes. The LPS Act was not intended to provide involuntary treatment to those who are mentally ill but are not a danger to themselves or others or who are able to provide for their own basic needs. It was also not intended to provide involuntary treatment for extended periods of time when individuals would otherwise be able to independently care for their own needs. Therefore, the criteria appropriately do not encompass people experiencing less acute symptoms of mental illness and are not meant to apply to individuals simply because they choose not to seek voluntary treatment. Expanding or revising the LPS Act's criteria for involuntary holds to include standards that are overly broad—such as the ability to live safely in one's community—could widen the use of involuntary holds and pose significant concerns about infringement on individual rights. We found no evidence to justify such a change.

However, the fact that the LPS Act's criteria for involuntary holds are sufficient for their purpose does not mean that the State is adequately caring for Californians with mental illnesses. In our review of cases that did not result in short-term holds, we found numerous instances in which individuals with mental illnesses were experiencing difficult circumstances that indicated their need for some level of mental health services although designated professionals determined that the symptoms of their mental illnesses did not rise to the level of the LPS Act's criteria for involuntary treatment. Further, involuntary holds are but one component of a more comprehensive mental health care system, and individuals who receive crisis intervention are not always being effectively served by that broader system. As we discuss in more detail later in this chapter, Los Angeles and San Francisco have high percentages of people who exited holds but were not enrolled in supportive services. Additionally, in Chapter 2, we explain that the State could more effectively serve individuals who cycle in and out of crisis care treatment if it expanded treatment options. Despite the current adequacy of the LPS Act criteria, significant change is necessary to ensure that the State is providing adequate mental health treatment to those who need it.

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The State and Local Governments Do Not Have Sufficient Treatment Capacity to Assist All Individuals Needing Services Under the LPS Act

State and local facilities lack adequate capacity to treat all individuals who require care under the LPS Act, and in some cases, this lack of capacity has jeopardized the well-being and safety of both individuals receiving treatment and facility staff.

At the local level, some counties have indicated that they do not have the adequate number or types of beds—such as for longer-term, around-the-clock treatment—to treat individuals near their communities.

Individuals receiving treatment under the LPS Act can require treatment space for both short-term and long-term periods of time. However, state hospital facilities have limited space to admit and treat individuals whom counties refer under the LPS Act because of rapidly increasing referrals and a competing obligation to treat individuals involved with the criminal justice system. Because of this shortage of beds, individuals treated under the LPS Act who were waiting for treatment in a state hospital facility as of August 2019 had waited on average one year for admission to a state hospital facility, and some had waited multiple years. While they waited for treatment space at a state hospital facility, some individuals received care that was not adequate for their level of need. Further, at the local level, some counties have indicated that they do not have the adequate number or types of beds—such as for longer-term, around-the-clock treatment—to treat individuals near their communities. However, of the counties we reviewed, only Los Angeles was able to more thoroughly demonstrate its current and future need for treatment space relative to its current capacity across different levels of care.

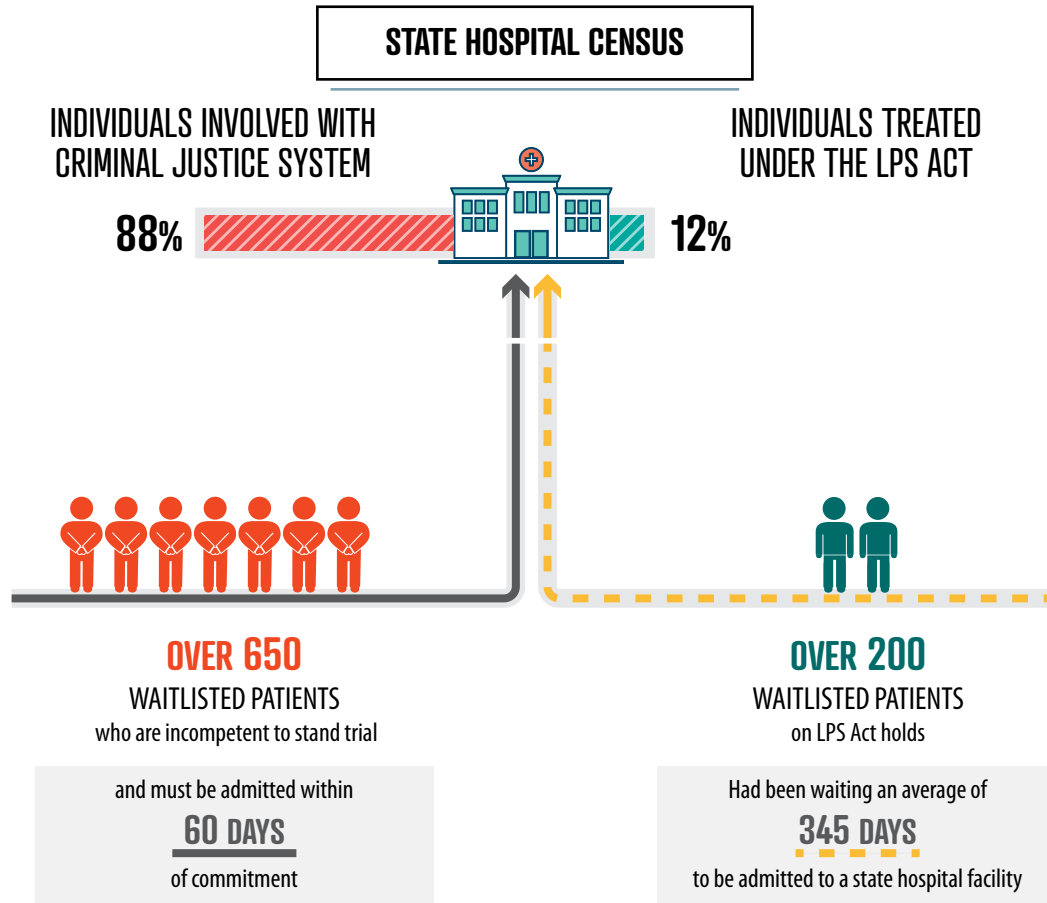
A Shortage of State Hospital Beds Has Compromised Treatment for Some Patients

When determining the correct placement for individuals receiving treatment through a conservatorship the counties generally considered similar factors. Documentation from Los Angeles and San Francisco and statements made to us by the chief deputy public guardian in Shasta indicated that the counties consider factors such as whether an individual's history includes episodes of violent behavior or leaving treatment facilities without authorization, which may necessitate a higher level of care. The counties also had similar policies for transferring people from more restrictive to less restrictive facilities when their treatment needs decreased, and we found that the counties considered individuals' symptoms and behaviors to identify the least restrictive setting that was appropriate to their needs. Generally, the counties had stepped individuals down to lower levels of care by the time their conservatorships terminated. As a result of their assessments for proper placement, counties may conclude that the most appropriate level of care for some individuals is in a state hospital facility.

Counties may base this determination on limited available private facility space and the fact that private treatment facilities can refuse to accept individuals who have severe symptoms, are violent, or have medical complications unrelated to their mental illnesses. According to the director of the Department of State Hospitals (State Hospitals), the providers in state hospital facilities generally have the advanced expertise necessary to treat individuals with serious mental illnesses who are the most difficult to serve. However, as of August 2019,

patients on State Hospitals’ waitlist who were being treated through the LPS Act had been waiting an average of about one year for a bed, as Figure 6 shows. In fact, two of these individuals had been waiting nearly three years to be admitted to a state hospital facility. Information that State Hospitals shared with us indicated that as of January 2020 there were 138 individuals being treated under the LPS Act in state hospital facilities that State Hospitals recommended be discharged, but who had not yet been discharged to lower levels of care. This factor certainly influences how long individuals receiving care under the LPS Act wait to be admitted to a state hospital facility. However, as we explain later in this section, we determined the primary factor that narrows access to state hospitals facilities is State Hospitals’ mandate to care for another significantly sized population of individuals

Figure 6
A Shortage of State Hospital Facility Beds Has Delayed Critical Treatment for Individuals Placed on LPS Act Conservatorships



Source: State Hospitals’ reported bed census data as of November 2019, the fiscal year 2019–20 May Revision to the Governor’s Budget, and auditor analysis of State Hospitals’ patient reservation data as of August 2019.

While individuals wait for space at a state hospital facility, they may not receive care that fully protects them or others around them.

Individuals waiting for admission to a state hospital facility sometimes receive inadequate levels of care while they wait. As we explain in more detail in the next section, the only county we reviewed that retained historical waitlist and referral information related to LPS placements was Los Angeles. Our review of that county's records found that while individuals were waiting for placement at a state hospital facility, they most often received their care in general acute hospitals or similar treatment facilities. However, Los Angeles's records demonstrate that in several instances, these lower levels of care created risk for both the waitlisted individuals and the staff of the facilities. For example, in one case, an individual exhibiting repeated self-injurious behavior was referred to a state hospital facility. While waiting for an available state hospital bed, they were taken off the state hospital facility referral list and admitted to a private facility. During their stay at the private facility, they engaged in additional self-injurious behavior, requiring several emergency room visits at a general hospital. Because of this behavior, the private facility would not readmit that individual to its care, so they remained at the general hospital. They were placed back on the state hospital's facility's waitlist, and the state hospital facility eventually admitted the individual three months after the second referral and five months after the initial referral. This case and others demonstrate that while individuals wait for space at a state hospital facility, they may not receive care that fully protects them or others around them.

State Hospitals has different populations who compete for space in its facilities, and legal mandates require it to treat individuals involved with the criminal justice system; however, these mandates do not exist for individuals receiving treatment through the LPS Act. In particular, state law permits individuals charged with certain felonies—whom courts have found incompetent to stand trial (IST defendants)—to be placed in a state hospital or other secured facility in order to be restored to competency. A significant body of case law has established that the due process rights of IST defendants include the right to timely and adequate treatment. State law generally requires IST defendants charged with certain felonies to be transferred to state hospital facilities for placement and allows for treatment at other facility types only under specified circumstances. According to recent case law, the State has up to 60 days from the date of commitment to a state facility by a court to admit an IST defendant. In addition to the legal obligation to preserve due process by quickly admitting these defendants, federal courts have more broadly required the State of California to address prison overcrowding and inadequate in-prison medical and mental health care. Further, state law requires State Hospitals to provide inpatient services to certain paroled offenders who pose a danger to others because of their mental illnesses unless the department certifies that there is reasonable cause to believe that the individual

can be treated effectively in an outpatient setting. Except under limited circumstances, the LPS Act does not similarly and explicitly require other individuals to be placed in state hospital facilities.

Because State Hospitals is legally required to treat individuals involved with the criminal justice system, state hospital facilities have comparatively few beds to treat individuals placed on a conservatorship through the LPS Act, even though those facilities may provide the most appropriate level of care. State Hospitals' data show that the total capacity in its facilities as of November 2019 was just under 6,300 beds and that 84 percent of these beds were occupied by individuals who were involved with the criminal justice system. At that time, individuals receiving treatment through the LPS Act occupied fewer than 720 beds—about 11 percent of bed capacity. According to its chief of fiscal and program research, State Hospitals typically maintains a bed occupancy rate of 95 to 97 percent, with vacancies occurring most often in units that are not available to the general patient population because they provide specialized services or medical treatment. She explained that vacancies in beds also occur because of the overall flow of patients as admissions, discharges, and temporary discharges take place.

As of February 2019, nearly 650 individuals statewide who had been found incompetent to stand trial were waiting to receive treatment at state hospital facilities to improve their mental condition. At the same time, 200 people receiving care through the LPS Act were also waiting for state hospital facility beds. While the average monthly population of individuals being treated under the LPS Act in state hospital facilities increased by about 28 percent from 2014 to 2018, the average number of individuals waiting for placement in a state hospital facility who were receiving treatment through the LPS Act increased by more than 500 percent, from an average of 31 individuals in fiscal year 2014–15 to an average of 197 in fiscal year 2018–19. Although State Hospitals has allocated some additional beds for individuals receiving their care through the LPS Act, it projects that this waitlist will continue to grow. The fact that courts or counties have determined that these individuals require care at state hospital facilities indicates that these facilities represent one of the few, if not only, opportunities for these individuals to obtain the treatment they need to improve their mental health. When the State does not provide timely access to treatment at state hospital facilities to those who need it, it fails to adequately care for these vulnerable individuals.

Despite the upward trend in the need for space at its facilities, State Hospitals has not acted to significantly increase its capacity to treat individuals on conservatorships. The director of State Hospitals stated that it has largely focused its requests for additional funding on the criminal justice population that it has a mandate to serve.

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In response to our request for the cost to reduce and stabilize its waitlist for individuals receiving treatment under the LPS Act, State Hospitals estimated that it needs an additional 330 beds and that the cost for staffing to support these new beds would be about \$85 million annually, in addition to one-time construction costs between \$250 million and \$425 million. However, the department cautioned that these numbers are preliminary and rough order-of-magnitude estimates and are not the result of a formal operational budget estimate or a formal construction estimate process performed by the Department of General Services.

Some Counties May Not Have Enough Beds to Treat All Patients Who Require Care

Beyond state hospital facility capacity, Los Angeles and Shasta reported that they have a shortage of local treatment beds for a variety of levels of care, while San Francisco could not state whether it has a need for additional local treatment beds, as we discuss later in the section. However, the three counties have not uniformly tracked the number of individuals waiting for placement. The Department of Health Care Services (Health Care Services) and State Hospitals do not require counties to report this information, nor did the three counties elect to send it of their own accord. As a result, although Los Angeles was able to demonstrate how many treatment beds it needs in comparison to its current capacity, San Francisco and Shasta did not have similar information.

Los Angeles has a robust assessment of its treatment bed capacity and needs. Its Department of Mental Health issued an extensive report to the county board of supervisors in October 2019 that assessed the shortage of mental health treatment beds in the county. The report included a discussion of the county's current and future needs for treatment beds and services, an assessment of all contracted beds, and plans for the creation of new beds. Among a wide range of recommendations for additional treatment resources and beds, the report concluded that the county needed more than 1,500 additional beds to serve individuals who need longer-term, around-the-clock treatment. Los Angeles also maintains historical information on its bed waitlists and referrals to certain types of facilities, and it has publicly stated that it is developing an application (app) for tracking the availability of mental health treatment beds throughout the county, including urgent care and crisis beds.

San Francisco and Shasta have not assessed their needs for treatment beds to the same extent as Los Angeles.

In contrast, San Francisco and Shasta have not assessed their needs to the same extent. Shasta does not maintain historical waitlist information, and San Francisco has only limited historical waitlist data. San Francisco's deputy director of care coordination in its

Department of Public Health stated that since February 2019, the department has tracked wait times until admission for individuals once they have been accepted to long-term care facilities, but it does not track wait-time data for individuals before acceptance. According to the deputy director, the department will begin tracking all referrals in July 2020. Although San Francisco has been increasing the number of its short-term psychiatric stabilization beds, a program coordinator for mental health reform in its department of public health stated that it has not completed a needs assessment similar to the one Los Angeles performed; however, the policy and planning director in that department stated that the county is working on a project to use modeling to simulate bed need, the results of which should be available in the summer of 2020. San Francisco also recently launched an app on a public dashboard to track bed resources for substance use disorder in the county, and according to the mental health reform program coordinator, the county plans to expand this public dashboard to mental health treatment beds soon.

Given Shasta's comparatively smaller size, it is able to know at a point in time each month how many people are waiting for treatment beds because county staff convene monthly to manage placement. Consequently, the county can roughly estimate its need for a limited number of additional beds. However, it does not have a comprehensive assessment based on its needs over a longer period.

Recent actions taken by the California Mental Health Services Authority (CalMHSA)—a joint powers authority composed predominantly of counties—also indicate that counties beyond those we reviewed require additional treatment bed capacity. In response to the shortage of available state hospital facility beds, CalMHSA has researched available sites for a new alternative to state hospital facilities. It has identified potential sites in two counties that could offer member counties additional beds for their residents being treated through the LPS Act. CalMHSA surveyed its member counties in 2018 to determine the total number and types of beds that they are interested in having in a new facility, which collectively ranged between nearly 80 to slightly more than 330 beds depending on the location.

Further complicating an assessment of the available treatment bed resources, neither Health Care Services nor State Hospitals tracks wait times or the need throughout the State for treatment facilities based on county-specific conditions or the demand for different levels of care. Public guardians and county mental health departments may struggle to place individuals at treatment facilities in their own counties because their facilities lack capacity or the ability or willingness to provide the needed services. In these contexts, counties sometimes place individuals at treatment

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facilities in other counties. For example, we noted that Shasta sometimes sends individuals for whom it is the conservator to Riverside County for placement. In Chapter 3, we present a potential solution for tracking statewide information about the resources counties use to provide treatment and the related outcomes. The State could thus better position itself to know when counties have treatment resource challenges through data collection efforts such as those we recommend in Chapter 3.

Los Angeles's Department of Mental Health and Superior Court Have Not Adequately Served Individuals on Conservatorship

Los Angeles's Department of Mental Health and superior court have engaged in practices that do not ensure that individuals subject to conservatorship receive adequate privacy protections and appropriate treatment. The Los Angeles Superior Court (Los Angeles Court) has held conservatorship proceedings in public settings instead of safeguarding the confidentiality of individuals' private health information, as the superior courts in San Francisco and Shasta have. Further, many conservatorships in Los Angeles ended when doctors failed to provide essential testimony in court proceedings. In these cases, the court could no longer authorize involuntary treatment, even though some individuals may have still needed it.

Los Angeles Court Has Not Acted to Protect the Privacy of Individuals in Conservatorship Proceedings

The Los Angeles Court has not provided the same level of privacy protection to individuals in conservatorship proceedings as San Francisco Superior Court (San Francisco Court) and Shasta Superior Court (Shasta Court). Case law holds that conservatorship proceedings are presumptively nonpublic, in part to protect individuals' privacy interests. Thus, unless a party to the hearing demands a public hearing, the law effectively requires that conservatorship court proceedings, during which confidential patient records may be discussed, be closed to the public. That mental illness can have a stigmatizing effect on those who are ill is widely acknowledged, and courts have recognized that conservatorship proceedings can pose a threat to the personal reputations of the people involved. The San Francisco Court and Shasta Court have mitigated this threat by holding conservatorship proceedings in closed courtrooms unless the individuals who are the subjects of the hearings grant access to outside parties. As a result, members of the public may not hear individuals' private information at conservatorship proceedings in these two counties, unless the individuals choose to have public hearings.

Case law holds that conservatorship proceedings are presumptively nonpublic, in part to protect individuals' privacy interests.

Contradicting legal precedent, the Los Angeles Court conducts conservatorship proceedings that are open to the public unless individuals specifically request closed hearings. Further, the court does not fully ensure that individuals are aware that they can make such a request. According to a judge at the Los Angeles Court, the court's practice is to presume that proceedings are open unless closed proceedings are requested. During these open proceedings, individuals in Los Angeles testify about their mental health and hear testimony about their medical records in the presence of many others, including medical providers, other individuals in conservatorship proceedings, and community members. The information discussed routinely includes individuals' full names, specific mental health diagnoses, medications, and symptoms. In effect, the practice of holding public conservatorship proceedings unless an individual requests a closed hearing contradicts legal precedent and potentially deprives individuals of their right to privacy during these proceedings.

The Los Angeles Court indicated to us that it believes conservatorship proceedings are not presumptively nonpublic and stated that its procedures are intended to maximize the number of cases it can handle in a fair and expeditious manner. We believe handling cases in a way that maximizes privacy and minimizes potential stigma is of overriding importance and a clear requirement under the law. The Legislature's express intent is to protect the dignity and privacy of the people being treated involuntarily under the LPS Act. Allowing public access to the confidential and sensitive information presented at court proceedings clearly contradicts that intent, creating a situation in which the very process meant to protect individuals' rights simultaneously threatens to erode them.

Further, the practice we observed in Los Angeles could be occurring elsewhere in the State. Data published by the Judicial Council of California (Judicial Council) show that the Los Angeles Court receives far more mental health-related court filings than any other court in the State. To the extent that other courts, because of their size or staffing, are facing workload pressures similar to those that the Los Angeles Court indicated it faces, they may be engaging in similar practices. In light of that and of the Los Angeles Court's incorrect interpretation of the law, we believe the Legislature should take steps to provide more explicit direction to courts. Although we believe case law, in conjunction with state law, makes it clear that conservatorship proceedings are to be held in closed courtrooms unless an individual demands a public hearing, the Los Angeles Court's incorrect interpretation and practices demonstrate that an explicit statutory prohibition would likely benefit the individuals whose privacy is at risk in these proceedings.

The Los Angeles Court's practice of holding public conservatorship proceedings unless an individual requests a closed hearing contradicts legal precedent and potentially deprives individuals of their right to privacy during these proceedings.

Los Angeles's Poor Coordination of the Conservatorship Process Has Disrupted Care

As we explain in the Introduction, a court can place an individual on a conservatorship if they are unable to meet their basic personal needs for food, clothing, or shelter because of a mental illness. Unless renewed, these conservatorships can be up to a year long and are ordered by a court following either a hearing or, if requested by the individual in question, a trial. An essential component of a conservatorship hearing or trial is the medical evidence that courts consider to determine whether the individual is unable to meet their basic personal needs because of a mental illness. A county seeking to impose or to renew a conservatorship must prove beyond a reasonable doubt that the person meets the grave disability criteria, which, at trial, is typically done by having a doctor testify and answer questions about the individual. However, in Los Angeles, 10 of the 20 conservatorship cases we reviewed were terminated when the county was seeking to renew the conservatorships, and six of those 10 conservatorships ended after doctors failed to testify. The presence of a doctor at the trial—as opposed to the doctor submitting written testimony to the court—is important because courts have found that one purpose of a trial is to provide the person who is the subject of a conservatorship proceeding the opportunity to cross-examine the doctor. In the six cases above, the court could not proceed because the doctors failed to testify; and as a result, the associated conservatorships terminated without renewal.

The effect of prematurely terminated conservatorships can be devastating.

The effect of prematurely terminated conservatorships can be devastating. One of these six cases involved an individual whose health had improved during the conservatorship period. However, they had limited insight into their illness and refused treatment after their conservatorship terminated. County documentation related to the case indicated that without treatment, the individual grew violent toward others and neglectful of their own well-being. In this case, the disruption to the individual's care caused harm and also did not facilitate their successful return to the community, as several months later the public guardian petitioned for another conservatorship, which the court granted.

Although we observed six cases in which a doctor's failure to testify at the trial meant that a conservatorship terminated, this breakdown in the conservatorship process is a widespread problem in Los Angeles. According to a February 2019 report from the director of Los Angeles's Department of Mental Health to the county's board of supervisors, nearly 20 percent—106 out of 618—of the conservatorships that ended in fiscal year 2017–18 did so because doctors did not testify in court. The deputy director of the Los Angeles Office of the Public Guardian (deputy director public guardian) explained that doctors are sometimes available

only on certain days and that the county attempts to schedule court proceedings for those days; for one case we reviewed, she indicated that the court scheduled a proceeding for a date on which the doctor was not available. She further noted that testifying in court is not a reimbursable medical service for private doctors, which may also factor into their absence. However, she also acknowledged that the county has not addressed this problem in a systemic manner. Instead, the county has implemented solutions case by case and only by, for example, attempting to resolve scheduling conflicts or, as a last resort, issuing subpoenas for doctors to testify.

A more comprehensive solution is available that the county has not used. Both the director of the Department of Mental Health and the deputy director public guardian told us that doctors employed by the county could testify at conservatorship trials as expert witnesses. Having them do so would provide the county with a reliable resource to provide essential medical testimony in those cases when an individual's treating doctor does not appear in court. According to the deputy director public guardian, the county has not implemented this solution in part because of concerns that the doctor providing care to the individual during conservatorship can provide more thorough testimony than an expert witness can present and that this fact may affect the effectiveness of the testimony. These concerns notwithstanding, Los Angeles' current practice is resulting in terminated conservatorships that may result in harm to individuals who still need care. In light of that, Los Angeles should do all that it can to attempt to continue conservatorships that it believes are benefiting individuals.

Los Angeles and San Francisco Have High Percentages of Individuals Who Were Not Enrolled in Ongoing Care After Leaving Involuntary Holds

Los Angeles's and San Francisco's lack of coordination with medical facilities has often left individuals who are released from involuntary holds without connections to county mental health treatment services. These connections are important because counties are responsible for implementing significant aspects of the LPS Act, and they also have critical responsibilities for delivering services as part of the State's public mental health care system. Thus, they are uniquely placed to ensure that individuals released from LPS Act holds are connected to the treatment they need. Treatment following a hold can range from appointments for wellness visits and therapy services to more intensive levels of care, such as full-service partnerships or assisted outpatient treatment programs. In particular, full-service partnerships and assisted outpatient treatment involve a personal case manager for each client who coordinates care across a variety of services, including psychiatric services and housing assistance. These programs are the most comprehensive and intensive

Counties are responsible for implementing significant aspects of the LPS Act, and they also have critical responsibilities for delivering services as part of the State's public mental health care system.

In Los Angeles, about one-third of the individuals from our case file review who had a high number of 72-hour holds in their lifetimes were not enrolled in these intensive outpatient service programs at any point from fiscal year 2016–17 through 2018–19.

methods available to all counties for providing community-based care to individuals with serious mental illnesses. According to guidelines published by the Center for Mental Health Services within the U.S. Department of Health and Human Services, meaningfully improving an individual's prospects for success after crisis intervention requires good discharge planning. The guidelines further note that crisis intervention is only one part of a larger system of care. The guidelines state that taking meaningful measures to reduce the likelihood of future emergencies is a key principle of providing crisis care. Nonetheless, the two counties have high percentages of individuals who were not enrolled in intensive services after leaving involuntary holds.

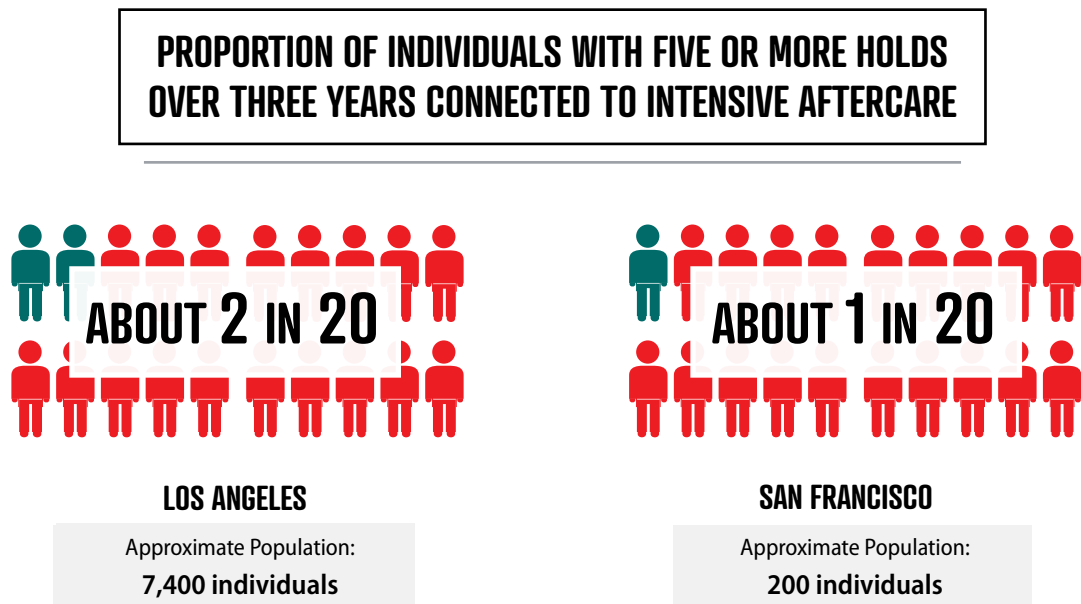
To assess the counties' success in ensuring ongoing county services, we identified all the people who had been placed on five or more short-term holds from fiscal years 2015–16 through 2017–18 and reviewed whether the counties had enrolled those individuals in full-service partnerships or assisted outpatient treatment in fiscal year 2018–19. Los Angeles had nearly 7,400 individuals with five or more short-term holds over that time, and only 9 percent of those individuals were enrolled in full-service partnerships or assisted outpatient treatment. The percentage of people enrolled in these intensive treatment services in San Francisco was even lower.⁵ Figure 7 summarizes these results. Because individuals with such a high number of short-term holds in three years represent a very high-need population, it is important that a much higher percentage of these individuals be connected to counties' most intensive treatment programs. In Los Angeles, about one-third of the individuals from our case file review who had a high number of 72-hour holds in their lifetimes were not enrolled in these intensive outpatient service programs at any point from fiscal year 2016–17 through 2018–19. These included one individual who had been held more than 10 times and had been refusing medication and threatening to kill others and themselves.

Additionally, we identified individuals from our case file review who had been placed on multiple short-term holds and then determined whether the counties had followed up with them in the two weeks following the hold to connect them to any type of service. In Shasta, only one person from our selection was a county resident and had been placed on multiple holds, and the county had connected that individual to supportive services. However, San Francisco did not provide supportive services to four of the six individuals we reviewed who had been held multiple times. Two returned to incarceration at the end of their holds. Similarly, Los Angeles did not provide services to six of the nine individuals we reviewed who had been held multiple times.

⁵ We do not present the number of individuals held five or more times in Shasta during this period to protect the confidentiality of these few individuals.

Figure 7

A Small Proportion of Individuals Who Were Held Multiple Times for Involuntary Treatment Were Then Enrolled in Intensive Outpatient Services in Los Angeles and San Francisco



Source: Analysis of data from the California Department of Justice about involuntary holds and county data on enrollment in outpatient services to determine the number of individuals who were involuntarily held five or more times from fiscal year 2015–16 through 2017–18 and then enrolled in full service partnerships or assisted outpatient treatment in fiscal year 2018–19.

Note: Values are approximated to protect the confidentiality of the individuals summarized in the data. For the same reason, results for Shasta County are not shown.

In Los Angeles and San Francisco, county staff presented several reasons why they might not have provided aftercare services to individuals who had repeatedly been involuntarily held for treatment. Specifically, these counties indicated that some individuals choose not to participate in the voluntary services that they offer. Both counties also stated that they might have provided these individuals with connections to other services beyond full-service partnerships and assisted outpatient treatment. Although this may be true, these two service types are comprehensive and intensive treatment programs. Therefore, we expected a greater percentage of high-need individuals to be connected to them. Los Angeles also noted that it has no mandate to serve individuals who are privately insured and can receive their mental health care through a private provider. However, among the randomly selected cases we reviewed—for which documentation was available in the involuntary hold records—we found that a high percentage of individuals were enrolled in Medi-Cal or had received county mental health services. Further, although our selection of cases suggests that the percentage of individuals

with private insurance is low, the presence of private health care coverage and other post-hold treatment options does not change the overall conclusion that Los Angeles and San Francisco have significant numbers of individuals who are not enrolled in intensive outpatient treatment despite being involuntarily held many times. For example, if half of the 7,400 individuals we identified as being held five or more times in a three-year span were privately insured, Los Angeles's enrollment rate in intensive mental health services among these individuals would still be only 17 percent. Finally, Los Angeles also offered other explanations for why its percentage of individuals enrolled in full service partnerships or assisted outpatient treatment was low. We assessed each of these reasons and found none of them adequately explained why such a high-need population would be so infrequently enrolled in intensive outpatient services.

Both Los Angeles and San Francisco are aware of the gaps in their ability to connect individuals leaving holds with aftercare. Table 1 summarizes these gaps. Los Angeles's staff acknowledged the weaknesses in the county's system for coordinating continued care with medical facilities, stating that in some cases the county is only aware of individuals being discharged from short-term holds if the treatment facilities holding them decide to notify it. San Francisco stated that it is aware of individuals who are placed on holds only at Zuckerberg San Francisco General Hospital and Trauma Center (Zuckerberg), one of its seven designated treatment facilities in the county. However, from January 2014 through October 2019, about 56 percent of individuals leaving short-term holds in San Francisco were leaving treatment facilities other than Zuckerberg. Further, the county explained that it does not receive automatic alerts about short-term holds even at this facility; instead, to know whether someone has been on a hold, the county must actively search for that individual's name—which severely limits the usefulness of the data for the purpose of connecting people to supportive services. The lack of knowledge of these two counties regarding short-term holds makes it difficult—if not impossible—for them to connect individuals to ongoing treatment.

The lack of knowledge of both Los Angeles and San Francisco regarding short-term holds makes it difficult—if not impossible—for them to connect individuals to ongoing treatment.

Los Angeles has connections it could expand with designated facilities to ensure that it is aware of individuals leaving holds so it can transition those individuals to the appropriate continuing treatment. Its Department of Mental Health provides liaisons to the county hospitals it operates, and these liaisons attempt to link individuals leaving holds to appropriate post-hold care. However, Los Angeles operates only three of the 49 designated facilities in the county. The interim director of the Department of Mental Health's intensive care division informed us that in January 2020, Los Angeles added liaisons to two additional hospitals as part of a pilot program. In addition, according to the director of

that department, the county plans to make improvements to its collection and analysis of data related to short-term holds, but the exact data that it needs and how it will obtain such data is still under discussion. If it improves its awareness of short-term involuntary holds, Los Angeles could then better coordinate care for individuals leaving those holds.

Table 1
Los Angeles and San Francisco Have Not Adequately Coordinated With Treatment Facilities to Ensure That Individuals Receive Ongoing Care

<i>The county mental health agency...</i>			
	... HAS A PROCESS TO ENSURE THAT IT IS AWARE OF ALL HOLDS.	... WORKS WITH ALL TREATMENT FACILITIES TO COORDINATE ONGOING CARE.	... FOLLOWS UP TO ENSURE THAT INDIVIDUALS WITH HIGH LEVELS OF NEED RECEIVE THE SERVICES THEY REQUIRE.
Los Angeles	X	X	X
San Francisco	X	X	X

Source: Interviews with staff, county documentation, and medical records in selected case files from Los Angeles and San Francisco.

San Francisco has also taken some steps to connect individuals to the ongoing care they need. It operates a number of lower-level treatment and residential facilities for individuals receiving care after a short-term LPS Act hold, and according to a social worker with San Francisco’s Department of Public Health, the county is aware of the need for follow-up care when a designated treatment facility discharges someone to one of these facilities. In addition, the county operates a number of small programs to which it attempts to connect individuals with complex needs, which it attested frequently includes individuals who have recently been on short-term holds. Although it is encouraging that Los Angeles and San Francisco have made some efforts to connect individuals leaving short-term holds to additional mental health services, there is more they must do.

The challenges that Los Angeles and San Francisco face in attempting to connect individuals to services following short-term holds are made worse by the lack of available data about those individuals’ previous short-term holds. Counties are largely unable to access information about when individuals are placed on short-term holds and when they are discharged. As we describe earlier, treatment facilities in the counties we reviewed do not always share information about short-term holds with the counties’ mental health departments. However, state law requires these

The sole possessor of the most comprehensive data about short-term holds—the Department of Justice—is an agency that does not have direct responsibility for overseeing or providing for mental health care.

facilities to report certain short-term holds to the California Department of Justice (Justice) so that Justice can use this information to determine whether individuals are prohibited from owning firearms.⁶ Although Justice has both express permission to and a valid business reason for possessing information about holds, state law deems that this information is confidential unless it is relevant to a court proceeding regarding an individual's right to own or possess a firearm, and Justice indicated that it has not entered into any interagency agreements with other state agencies or county mental health departments to share these data. In other words, the sole possessor of the most comprehensive data about short-term holds is an agency without direct responsibility for overseeing or providing for mental health care.

Because counties cannot access statewide data about short-term holds, they lack information that might enable them to provide adequate ongoing care to individuals with mental illnesses. Even if counties were to develop local agreements with their designated facilities to share information, that would still leave counties without information about individuals' holds in other counties. This information could be essential to knowing what types of services an individual requires. For example, staff at all three counties we reviewed stated that they may make different decisions about the level of follow-up care to support an individual who they believe has been only held once versus someone they know has been held three or four times in the recent past.

The State would experience at least two benefits if the Legislature allowed Justice to share its repository of information about short-term holds with Health Care Services. First, the agency that is primarily responsible for administering the LPS Act would have access to significant and important data about the use of the act. State law charges Health Care Services with collecting and publishing quantitative information concerning LPS Act holds. However, state law prohibits Health Care Services from having any information that would reveal individuals' names, and the information it does possess is limited and incomplete. The problems with its data are substantive enough that when we were considering how to answer straightforward questions for this audit—such as how many times individuals were placed on short-term holds—we determined that we had to base our conclusions on data we obtained from Justice rather than Health Care Services. If the Legislature granted Health Care Services permission to access the treatment facility reports that Justice maintains, it would likely enhance its ability to oversee the implementation of the LPS Act.

⁶ Under state law, individuals who are the subject of short-term holds are prohibited from owning or possessing a firearm for a period of five years from the date of the hold, or under certain conditions, for the remainder of their lives.

Second, if Health Care Services had more complete data, it would be able to share information about short-term holds with counties. As we describe earlier, counties cannot easily access information about an individual's previous short-term holds, even though this information may be valuable to them in making decisions about the type of services with which to connect people. If Health Care Services had access to comprehensive data about short-term holds and express permission in state law to share those data, it could make information about previous holds available to counties when individuals are held at treatment facilities in their jurisdictions. To protect individuals' privacy, Health Care Services should ensure that counties can only access information about short-term holds for residents and allow access to out-of-county residents' information only when they are placed on holds and only for the duration of that treatment. Further, this change would allow Justice to continue to maintain the data it needs to determine whether individuals can legally own firearms.

Finally, the Legislature would need to take one additional action to ensure that the information that Health Care Services shares with counties is as complete as possible. Treatment facilities are not currently required to report to Justice short-term holds that are the result of grave disability. Therefore, any holds resulting from this criterion would not be among the information that Justice would share with Health Care Services. To address this gap in information, the Legislature could require treatment facilities to report all short-term holds resulting from grave disability directly to Health Care Services.

Recommendations

Legislature

To ensure that counties are able to access important data about individuals whom they place on involuntary holds under the LPS Act, the Legislature should amend state law to do the following:

- Require Justice to make the information that mental health facilities report to it about involuntary holds available to Health Care Services on an ongoing basis.
- Require treatment facilities to report to Health Care Services all short-term holds that result from the grave disability criterion.
- Direct Health Care Services to obtain daily the mental health facility information from Justice and make that information, as well as the information that facilities report directly to it,

Counties cannot easily access information about an individual's previous short-term holds, even though this information may be valuable to them in making decisions about the type of services with which to connect people.

available to county mental health departments for county residents, and for a limited time for nonresidents on an involuntary hold within the county.

To ensure that it is informed about the costs of providing adequate care to individuals treated through the LPS Act, the Legislature should require State Hospitals to report by no later than April 2021 about the cost of expanding its facilities' capacities to reduce and stabilize the LPS waitlist. The report should include a range of options including, but not limited to, reducing the LPS waitlist to limit wait times to within 60 days.

To protect the privacy of individuals who are the subject of conservatorship proceedings, the Legislature should amend state law to explicitly prohibit these proceedings from being open to the public unless the subjects of the proceedings direct otherwise.

San Francisco and Shasta

To evaluate and address shortages in the capacity of their treatment facilities, San Francisco and Shasta should, by August 2021, conduct assessments that determine the number and type of treatment beds that they need to provide adequate care for individuals who require involuntary treatment. Once the counties complete the assessments, they should adopt plans to develop the needed capacity.

Los Angeles and San Francisco

To ensure that they connect patients who have been placed on multiple short-term holds to appropriate ongoing treatment, Los Angeles and San Francisco should, by no later than August 2021, adopt systematic approaches to identifying such individuals, obtaining available mental health history information about these individuals, and connecting these individuals to services that support their ongoing mental health.

Los Angeles

To ensure that conservatorships do not terminate because of the absence of testimony from doctors, Los Angeles should immediately implement a comprehensive solution to this problem, such as using its own staff as expert witnesses when individuals' treating physicians are unable to testify. In addition, by no later than August 2021, it should develop a revised approach to scheduling conservatorship hearings and trials so that it significantly reduces the rate at which doctors' failures to testify result in terminated conservatorships.

Chapter 2

STATE LAW LIMITS COUNTIES' ABILITY TO EFFECTIVELY TREAT INDIVIDUALS WHO REQUIRE INVOLUNTARY OUTPATIENT CARE

Chapter Summary

Individuals in Los Angeles, San Francisco, and Shasta were repeatedly placed on involuntary holds and conservatorships by designated professionals, such as medical facility staff, and by courts. Although those with mental illness who cycle through involuntary treatment receive frequent care, the intended outcome of that care is to prevent immediate harm rather than to promote long-term recovery from the symptoms of their mental illnesses. This type of recovery generally requires ongoing outpatient treatment rather than crisis care. Many of the individuals who were placed on repeated conservatorships struggled to maintain their stability after leaving the treatment facilities, in large part because they frequently failed to take medication that was essential to managing their symptoms. State law already includes a less restrictive involuntary treatment option—assisted outpatient treatment—that could support these individuals in their efforts to maintain stability in their communities so that they do not cycle back to restrictive involuntary holds. By amending requirements for assisted outpatient treatment, the Legislature could improve counties' ability to effectively serve individuals who require this level of care.

Many Individuals Are Subject to Repeated Short-Term Holds and Conservatorships

The LPS Act's short-term holds and conservatorships do not sufficiently provide the ongoing care that some individuals need to remain healthy. Our review found that many individuals have repeatedly cycled in and out of short-term involuntary holds or in and out of conservatorships. These individuals likely also need intensive care while they are in their communities rather than involuntary treatment under the LPS Act alone. However, the nature of their mental illnesses can make ensuring that they receive voluntary treatment challenging.

Many people in each of the three counties we reviewed were placed on involuntary holds multiple times, and some were placed on a high number of holds, indicating that these individuals repeatedly received crisis care.

The Counties Held Thousands of Individuals More Than Once, Some of Whom Cycled Through Many Involuntary Holds

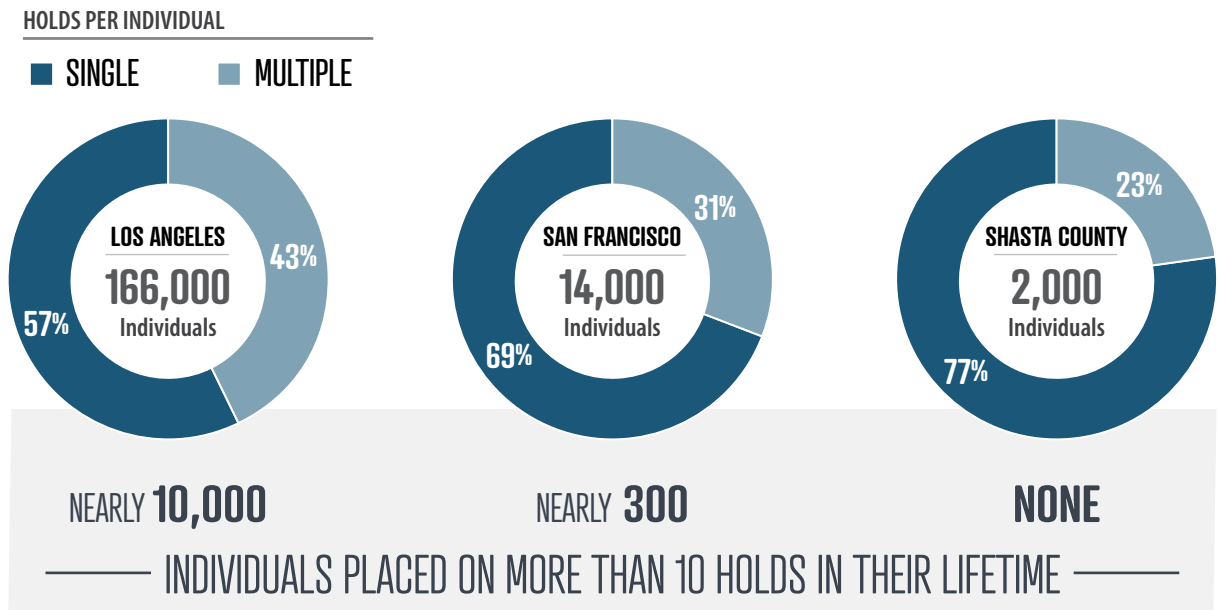
In alignment with the Legislature's intent to end the inappropriate, indefinite, and involuntary commitment of persons with mental illness, state law requires individuals on 72-hour holds to be released before the 72-hour period has elapsed if designated professionals determine they no longer require evaluation or treatment through an involuntary hold. However, there is a meaningful difference between being stable enough to be released from an involuntary hold and being able to maintain self-care and sustained mental health. Therefore, people who are released from short-term holds are still at risk for experiencing difficult and disruptive symptoms of their mental illnesses and potentially requiring additional involuntary holds to receive care.

Many people in each of the three counties we reviewed were placed on involuntary holds multiple times, and some were placed on a high number of holds, indicating that these individuals repeatedly received crisis care because of symptoms related to mental illness. As Figure 8 shows, Los Angeles had the highest percentage of repeated 72-hour holds. Los Angeles also had the highest number of individuals placed on multiple short-term holds; in fact, from fiscal years 2014–15 through 2018–19, Los Angeles's designated professionals placed more than 500 people on 72-hour holds who had each already been subject to at least 50 prior holds. These numbers are troubling because they indicate that these individuals consistently had difficulty managing their mental illnesses. The crisis care they received during involuntary holds, on its own, did not help them achieve long-term recovery or stabilization.

Further, experiencing repeated crises can have negative effects on people. Crisis care can itself be traumatic, particularly when individuals cycle through it more than once. Each hold can include aspects of care that are likely stressful and may even seem punitive to the individual being held, including being taken into custody by law enforcement, placed in seclusion, or put in physical restraints at a treatment facility. Further, mental health research and literature suggest that psychosis in general, and repeated psychotic episodes in particular, may cause physical damage to the brain and make treatment more difficult.

Finally, crisis care is costly for treatment facilities and counties. The counties and treatment facilities we reviewed estimated that providing services during one 72-hour hold can cost a treatment facility between about \$2,800 and \$8,400, depending on the type of facility. These costs largely relate to services that psychiatrists or other professionals provide during the hold. In addition, Shasta indicated that it can incur administrative costs as well.

Figure 8
Many Individuals Have Been Subject to Multiple Short-Term Holds



Source: Analysis of Justice’s mental health holds data.

Note: This analysis includes the lifetime total number of 72-hour holds for individuals with a hold or conservatorship between fiscal years 2014–15 and 2018–19. However, we excluded 6 percent of the 72-hour holds in our audit period from this analysis because we could not associate each of these holds with a unique individual for reasons such as a blank date of birth or a likely fictitious name.

Many Individuals Experienced Multiple Conservatorships Because Their Mental Health Deteriorated After Their Involuntary Treatment Ended

In addition to the people who cycled through short-term holds multiple times, 18 of the 60 people whose conservatorship cases we reviewed had been placed in conservatorships more than once. About one in four people—14 of the 60 people whose conservatorships we reviewed—were placed on conservatorship again despite having successfully recovered during a previous conservatorship. Individuals who are subject to repeated conservatorships are of particular concern because each conservatorship can represent years spent in a restrictive treatment facility, away from loved ones and community life. The average total time that individuals in the 60 cases we reviewed were held in conservatorships was about three years.

The individuals in those 18 cases who were subject to multiple conservatorships typically experienced deteriorating mental health while living independently. In four cases, these individuals’ conservatorships terminated for reasons such as doctors not testifying. However, in 14 of the 18 cases, the individuals left conservatorship because they had recovered their ability to provide for basic needs. Afterward, however these people experienced

symptoms of mental illnesses that compromised their ability to continue to care for themselves or exposed them to risks. For example, delusions interfered with one person's ability to maintain housing; another person who was experiencing disorganized thoughts lost a significant amount of weight after neglecting to eat, even though they had funds for food and offers of assistance. These declines occurred despite the fact that after they left conservatorship, most of these individuals—unlike many of those discharged from short-term involuntary holds—were connected to or offered continuing mental health services while living in their communities.

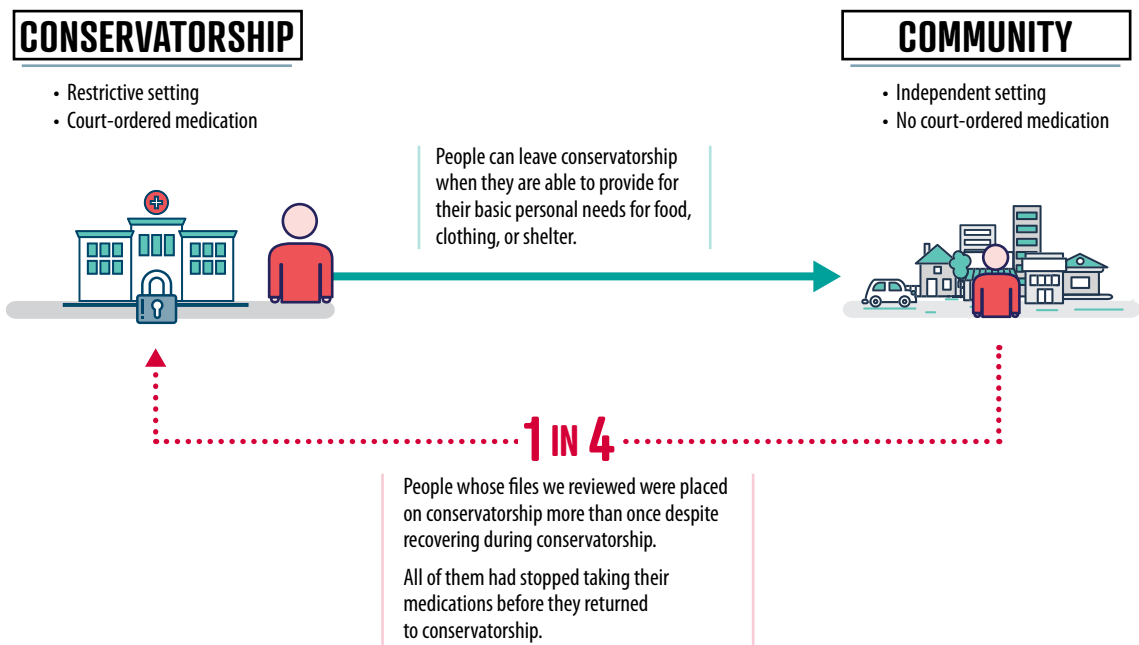
A key reason these individuals' conditions worsened was their illnesses made it extremely difficult for them to voluntarily take the medications that were critical to their continued health. All but one of the 60 people whose conservatorships we reviewed had a history of not taking medication or limited understanding that they had mental illness. For example, people diagnosed with schizophrenia, which interferes with one's perception of reality, often did not recognize that they had a mental illness, even though their symptoms were severe enough that they had qualified as gravely disabled and therefore were placed on conservatorships. Most of the 14 people whose cases we reviewed who were subject to repeated conservatorships had incomplete awareness of their illnesses, and some also believed medications could be poisoning them or causing unusual behavior. Figure 9 illustrates why certain people cycled through multiple conservatorship periods. We found that they frequently recovered during conservatorship, then stopped taking medication after they returned to their communities, and, as a result, eventually were placed on conservatorship again.

Under the LPS Act, and in keeping with its intent, a conservatorship must end when the individual is no longer unable to provide for their basic needs because of their mental illness. The case files we reviewed documented the damage that symptoms had inflicted on people's lives before their conservatorships: delusions interfered with their ability to work, paranoia strained their relationships with family, and disorganized thinking led to behaviors for which they were arrested. These symptoms became manageable for many individuals during conservatorship, when courts could grant the conservators the authority to administer the medication that was essential to recovery. In fact, two-thirds of the 60 conservatorships we reviewed ended when public guardians or courts found that the individuals demonstrated they were no longer gravely disabled by their mental health conditions; in other words, their treatment had achieved the

Two-thirds of the 60 conservatorships we reviewed ended when public guardians or courts found that the individuals demonstrated they were no longer gravely disabled by their mental health conditions.

desired results.⁷ Nonetheless, many individuals who were subject to multiple conservatorships stopped taking the medication after their conservatorships terminated and, as a result, some experienced effects such as homelessness or incarceration that further degraded their quality of life. These individuals' experiences suggest the need for the State to do more to ensure that counties can meet their needs, as we discuss in greater detail in the next section.

Figure 9
Many People Cycled Back to Conservatorships After They Stopped Taking Their Medications



Source: Analysis of selected case files from the three counties we reviewed.

Counties Have Only Limited Ability to Use the LPS Act to Provide Involuntary Outpatient Treatment

Without continuous intensive treatment, some individuals in the cases we reviewed cycled through restrictive involuntary holds, experienced homelessness and incarceration, and refused medication. To reduce inappropriate, indefinite, and involuntary commitments, the LPS Act intends that individuals will receive services in the least restrictive setting appropriate to their needs. To meet this goal, assisted outpatient treatment—which can provide involuntary treatment in a community setting—may be necessary

⁷ We detail the reasons for the terminations of the 60 conservatorship cases we reviewed in Table C.6 of Appendix C.

for some individuals with serious mental illnesses who lack insight into their conditions, and evidence shows it successfully improves outcomes. However, counties face limitations offering assisted outpatient treatment to some individuals because of restrictions in state law that make it difficult to use this treatment option as a step-down program from conservatorship and because it does not explicitly allow medication to be ordered as a part of treatment plans. Although San Francisco has adopted an innovative approach to its conservatorship program that allows for supervising medication in a community setting, the Legislature could foster a more uniform, statewide solution by revising the LPS Act.

Fewer Than a Third of California's Counties Have Adopted Assisted Outpatient Treatment

Since 2003 the LPS Act has allowed—but not required—counties to adopt assisted outpatient treatment programs.⁸ These programs serve individuals in need of intensive mental health treatment who do not meet the criteria for an involuntary hold or conservatorship. Under state law, assisted outpatient treatment can either be court-ordered or voluntary. Consistent with the LPS Act's emphasis on providing care in the least restrictive environment, assisted outpatient treatment programs must ensure that the individuals they treat are in the most independent and least restrictive housing available in the community. State law requires counties that provide assisted outpatient treatment to include services such as psychiatric and psychological services, vocational rehabilitation, substance abuse services, and assistance with housing. Further, state law requires that counties use highly trained mental health teams that assign a high number of staff to each client, and the law specifies that every person receiving assisted outpatient treatment must have a clearly designated mental health personal services coordinator. Counties that operate assisted outpatient treatment programs are required by the LPS Act to report information about their programs to Health Care Services.

The State's approach of allowing counties to choose whether to adopt assisted outpatient treatment programs is in contrast to New York, which has required local governments to operate assisted outpatient treatment programs since 1999.

The State's approach of allowing counties to choose whether to adopt assisted outpatient treatment programs is in contrast to New York, which has required local governments to operate assisted outpatient treatment programs since 1999. Research in New York has shown this treatment approach has substantially reduced both psychiatric hospitalizations and the likelihood of arrest. Researchers have also identified that individuals with mental illnesses are significantly more likely to possess adequate supplies of their prescribed medications if they are receiving assisted outpatient treatment.

⁸ The Legislature's authorization of assisted outpatient treatment is not permanent and is set to expire on January 1, 2022. However, the Legislature has extended the authorization for this treatment option several times in the past.

However, despite the potential benefits of assisted outpatient treatment, only 19 of California's 58 counties have reported to Health Care Services that they have adopted these programs. Because the three counties we reviewed have all adopted either full or pilot assisted outpatient treatment programs, we assessed the reasons why three additional counties—Butte County (Butte), San Bernardino County (San Bernardino), and Santa Clara County (Santa Clara)—had not yet done so.⁹ Behavioral health commission meeting minutes and statements from county supervisors and behavioral health directors indicate that San Bernardino has been reluctant to adopt another program that would need to be funded, and Santa Clara and San Bernardino expressed concern about how assisted outpatient treatment might be redundant to existing programs. In 2016 Butte's behavioral health department raised concerns about the level of resources needed to support assisted outpatient treatment, the lack of an enforcement mechanism to ensure participation in treatment, and limited data from counties with programs. However, at a January 2020 meeting of its Board of Supervisors, Butte discussed its plans to adopt a pilot assisted outpatient treatment program if it were awarded grant funding. Chapter 3 of this report presents possible funding options to support the establishment and expansion of assisted outpatient treatment programs.

The requirements for assisted outpatient treatment present challenges to successfully enrolling individuals in the treatment. Before a court can compel an individual to participate in assisted outpatient treatment, the county must be able to demonstrate that it has offered the individual assisted outpatient treatment services and that the individual failed to engage in treatment. The three counties we reviewed each satisfies this criterion by demonstrating a sufficient period of outreach to individuals offering them voluntary services. According to county staff in San Francisco and Los Angeles, the minimum period of outreach and engagement before each county may attempt to pursue a court order is 30 days. A social worker in Shasta's Health and Human Services Agency explained that it determines the appropriate duration of outreach case by case. Thus, in all three counties, the outreach period for obtaining voluntary participation may slow access to treatment. Further, the records from Los Angeles and San Francisco show that a common reason that they did not enroll individuals in assisted outpatient treatment was that they were unable to locate those who had been referred for the services. San Francisco explained that in many cases it makes attempts to contact referred individuals but cannot locate them because those individuals have had very limited to no previous contact with its assisted outpatient treatment care team.

Despite the potential benefits of assisted outpatient treatment, only 19 of California's 58 counties have reported to Health Care Services that they have adopted these programs.

⁹ We selected these counties because of the range of locations, sizes, and populations that they represent.

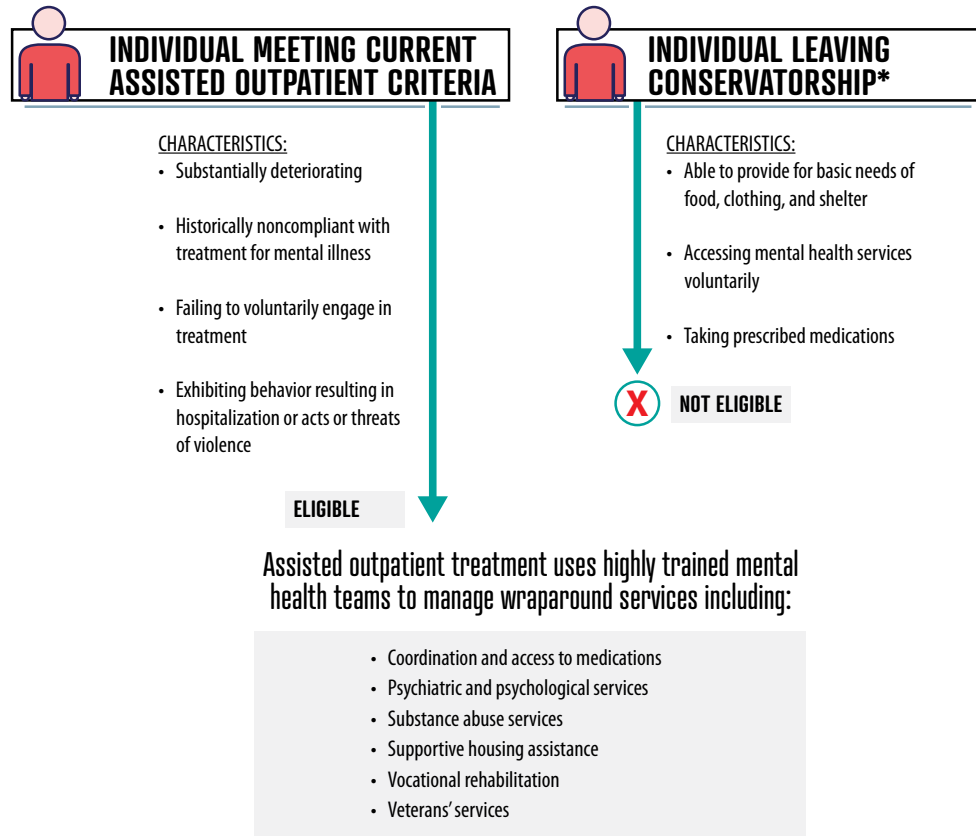
Because the requirements to exit a conservatorship are inconsistent with the eligibility criterion for assisted outpatient treatment, individuals are left without access to the type of help that could stop them from cycling through the crisis care system.

Changes to the LPS Act's Criteria for Assisted Outpatient Treatment Could Help Counties Serve Individuals Who Cycle Through Involuntary Holds

The LPS Act's existing eligibility requirements for involuntary assisted outpatient treatment are a barrier to participation for some of the people who would benefit from the program. Specifically, as we previously explain, some individuals on conservatorships have psychiatric histories that indicate they face a high risk of returning to restrictive institutional care if they do not receive medication and continuing intensive services after their conservatorships end. However, under the LPS Act's criteria for assisted outpatient treatment, individuals exiting from conservatorships are unlikely to be eligible for court-ordered participation in the program, as Figure 10 shows. Specifically, to receive this treatment, individuals' conditions must be substantially deteriorating. Further, within specified recent time frames, either they must have been hospitalized or received services in a mental health unit at least twice, or they must have committed, attempted, or threatened serious acts of violence toward themselves or others as a result of their mental health conditions. In contrast, state law requires that conservatorships end when a court determines that individuals are no longer gravely disabled—in other words, they are able to care for their own basic needs. Thus, these individuals are unlikely to satisfy the criterion that they are substantially deteriorating. Because the requirements to exit a conservatorship are inconsistent with the eligibility criterion for assisted outpatient treatment, individuals are left without access to the type of help that could stop them from cycling through the crisis care system.

Counties could transition individuals who leave conservatorships to involuntary assisted outpatient treatment if the Legislature expanded the eligibility criteria for that treatment. Counties could then use involuntary assisted outpatient treatment as a bridge from an LPS Act conservatorship to less intensive, voluntary services in the community while still providing services that could help individuals remain stable and healthy. Although this step-down approach would represent a continuation of involuntary care, the LPS Act includes numerous protections to prevent indefinite enrollment in involuntary assisted outpatient treatment. For example, initial enrollment cannot exceed six months, and once a court orders an individual to participate in assisted outpatient treatment, the director of the treatment program must file a written statement with the court every 60 days to affirm that the individual continues to meet the program's criteria. Finally, during each 60-day interval, the individual can petition the court to require that the director of the program prove that the individual still meets those criteria.

Figure 10
Assisted Outpatient Treatment Helps Some Individuals Receive Critical Treatment in Their Communities, But Its Criteria Limit Access for Those Who Recently Were Gravely Disabled



Source: State law, county policies, and auditor analysis of case files.

* Conservatorships can end when individuals are able to provide for their basic needs, but through our case file review, we observed that conservatorships could also lead to other positive outcomes including those represented here.

Further, although the LPS Act permits courts to order assisted outpatient treatment plans that provide for coordination and access to medication, it does not explicitly permit courts to order medication that may be essential to an individual's successful transition to living in their community. As we indicate in the previous section, we found that medication was a central element that allowed many of the individuals who were subject to conservatorships to reach a point where the court no longer found them to be gravely disabled. However, a lack of insight into their mental illnesses can cause some people to stop taking medication. Absent limited circumstances, the LPS Act explicitly prohibits court-ordered assisted outpatient treatment plans from including involuntary medication—in other words, medication that treatment providers would forcibly administer. However, the LPS Act neither explicitly prohibits nor allows counties to include in treatment plans

California's assisted outpatient treatment program contrasts with the practice in at least 12 other states, whose versions of outpatient treatment expressly permit court-ordered medication for individuals living in the community.

that an individual will self-administer medication. In other words, the LPS Act does not explicitly permit courts to order medication as part of such plans.

California's assisted outpatient treatment program contrasts with the practices in at least 12 other states, whose versions of outpatient treatment expressly permit court-ordered medication for individuals living in the community. For example, in New York, an assisted outpatient treatment plan can include court-ordered medication to treat a person's mental illness and specifies that the treatment plan must describe how the medication will be administered and the type and dosage of the medication. If California explicitly allowed for court-ordered medication as a component of assisted outpatient treatment, it would provide counties an important tool for ensuring that individuals with a high risk of noncompliance continue to take the medication that helps them maintain stability.

Additionally, the State would benefit from adopting clear enforcement mechanisms for court-ordered medication. According to the most recent available report from Health Care Services on the implementation of assisted outpatient treatment programs, counties have used methods such as increasing the number of status hearings before the court to try to encourage medication compliance during assisted outpatient treatment. If California expressly permitted court-ordered medication as part of an assisted outpatient treatment plan, it would also benefit from clear enforcement mechanisms. A resource document from the American Psychiatric Association suggests that court hearing officers clearly express that taking medications is an expected behavior if individuals hope to avoid hospitalization. Further, assisted outpatient treatment teams already have the capacity to visit an individual's residence and could supervise them taking their medication, if requested. If an individual refuses to comply with court-ordered medication, the American Psychiatric Association suggests this should constitute sufficient evidence of lack of compliance and cause the team to take that person to an outpatient facility for treatment. At the facility, the individual would again be offered medication but would not be forced to take it. This gradual process of progressive measures to promote adherence, short of force, would likely facilitate compliance for many individuals and help to prevent rehospitalization. The State could also adopt similar approaches to encouraging compliance with other areas of the individual's treatment plan.

Using this approach, counties could better ensure that individuals whose conservatorships have ended continue to take medication that keeps them from needing more restrictive care. Although court-ordered medication under these circumstances could be

considered a further restriction of individual rights, we believe that requiring people to take medication while living within their communities ultimately provides them more freedom than if they were required to take medication while placed on short-term involuntary holds or in some conservatorship settings. Our review of conservatorships and the significant role that medication noncompliance plays in some individuals' returns to conservatorships shows that court-ordered medication may represent treatment in the least restrictive care environment, which is the intent of the LPS Act. Provided that decisions about court-ordered medication result from a process in which individuals are able to argue against the medication orders if they so desire, the State would appropriately balance the restriction of individuals' rights with its goal of treating them in the least restrictive environment.

The counties we reviewed agreed that assisted outpatient treatment as a step-down from conservatorship would be an effective approach to keeping people stable and in the least restrictive environment possible. The director of Los Angeles's Department of Mental Health stated that involuntary assisted outpatient treatment tied to the end of a conservatorship with the option of court-ordered medication would eliminate the period of outreach and engagement—meaning individuals might receive treatment sooner—and also stated that clear authority to include medication would help treatment plans to be more successful. San Francisco's director of Justice-Involved Behavioral Health Services agreed that such an approach might be beneficial and that it would still represent a less restrictive treatment setting for individuals than conservatorship. The former branch director of Adult Services for Shasta's Health and Human Services Agency agreed that an option for assisted outpatient treatment plans that includes court orders for medication is sound as long as staff members understand that they do not have legal authority to forcibly medicate clients.

Finally, assisted outpatient treatment has been a cost-effective approach to treating individuals with serious mental illness. A December 2013 article in the *American Journal of Psychiatry* found after a comprehensive cost analysis of New York's assisted outpatient treatment program that such treatment requires a substantial investment of resources but can reduce overall service costs for individuals with serious mental illness—with substantially reduced costs for inpatient mental health treatment. The article reports that in the state of New York, where courts can order medication for participants, average costs for those enrolled in assisted outpatient treatment declined by 50 percent in New York City and by 62 percent in a broader, five-county sample compared to average costs pre-enrollment. Further, in March 2019, San Francisco issued a three-year evaluation report on assisted

We believe that requiring people to take medication while living within their communities ultimately provides them more freedom than if they were required to take medication while placed on short-term involuntary holds or in some conservatorship settings.

outpatient treatment that estimated an average monthly savings of over \$400,000 for its pool of 129 participants—a reduction of about 83 percent compared to average costs before enrollment.

San Francisco Has Created an Alternative to Assisted Outpatient Therapy, But a Uniform Approach Would Better Serve All Counties

San Francisco has developed two conservatorship programs that allow its public guardian to oversee court-ordered medication for some patients living in the community (community conservatorships). These programs serve individuals who face the possibility of conservatorship in restrictive treatment facilities, such as locked facilities, but who could likely live safely in the community if they took their prescribed medications. Once conservatorship is established, the court grants the public guardian the right to require the individuals to receive psychiatric treatment, and the public guardian places the individuals in community housing instead of treatment facilities. The programs also connect individuals to case managers and outpatient services.

As part of one of San Francisco's community conservatorship programs, individuals may also choose to participate in a collaborative court program that further supports their transition to fully voluntary treatment. This program serves individuals who are willing to voluntarily accept conservatorship and be subject to a court order for medication. Each month, the individuals, their case managers, the public guardian, and the public defender report to a judge to ensure that the individuals are engaging in treatment successfully. We saw evidence that this program has led to positive treatment outcomes, such as individuals returning to family homes, holding jobs that align with their ability to meet their basic needs, and engaging in relationships and activities in their communities. San Francisco's analysis indicates that this program has saved the county an average of as much as \$10,000 per person per month because the individuals who participated in it used services like crisis care and hospitalization less frequently.

This program has led to positive treatment outcomes, such as individuals returning to family homes, holding jobs that align with their ability to meet their basic needs, and engaging in relationships and activities in their communities.

Although the community conservatorship option has been successful in San Francisco, neither Los Angeles nor Shasta offers a similar program, and officials in those counties indicated concerns about the feasibility of creating one. For example, the deputy director public guardian for Los Angeles explained that neither the cooperation necessary to administer medication in a community setting nor collaborative court hearings might be feasible in Los Angeles. However, the court-ordered assisted outpatient treatment programs we previously described must be composed of community-based, multidisciplinary, and highly trained mental health professionals who work together to provide

a wide range of services to individuals. Because the assisted outpatient treatment option is recognized as successful and involves these professional supports that conservatorships do not, we believe that it would be the more effective solution for the State. Amending the requirements in the LPS Act related to assisted outpatient treatment would support a uniform approach to treating people who need court-ordered medication but who do not need restrictive, facility-based care.

Recommendations

Legislature

To allow counties to provide effective treatment to individuals in the least restrictive setting, the Legislature should amend the criteria for assisted outpatient treatment programs to do the following:

- Allow individuals who are exiting or have recently exited conservatorships to be eligible for those programs.
- Provide express authority to include medication requirements in court-ordered assisted outpatient treatment plans so long as the medication is self-administered.
- Include progressive measures to encourage compliance with assisted outpatient treatment plans, such as additional visits with medical professionals and more frequent appearances before the court.

Further, the Legislature should amend state law to require counties to adopt assisted outpatient treatment programs. However, to ensure the counties' ability to effectively implement such programs, the amended law should allow counties to opt out of adopting assisted outpatient treatment programs by seeking a time-limited waiver from Health Care Services. The Legislature should require a county seeking a waiver to specify what barriers exist to adopting an assisted outpatient treatment program and how the county will attempt to remove those barriers. The Legislature should require Health Care Services to make a final determination as to whether a county will be permitted to opt out of adopting an assisted outpatient treatment program.

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Chapter 3

THE STATE DOES NOT KNOW THE EXTENT TO WHICH BILLIONS IN FUNDING HAS ASSISTED INDIVIDUALS WITH MENTAL ILLNESSES

Chapter Summary

California invests billions of dollars each year in county mental health services, yet policymakers and other stakeholders remain unable to easily or fully understand the impacts of that spending on individuals with mental illnesses. Counties can use any of their major mental health funding sources to provide a range of programs and services that may ultimately reduce the need for LPS Act holds. However, despite the wide variety of services counties can provide, the State's current public reporting for mental health funds relies on disjointed and incomplete tools—a result of multiple funding sources with different requirements and levels of transparency.

We outline here a framework for overhauling mental health reporting that includes capturing information across all major funding sources, reporting counties' spending in useful and uniform categories, and publishing robust outcomes for counties' specific programs and for the State's overarching mental health system. Without such a framework for consolidating information about the full range of mental health services, the State will remain unable to understand the effects of its investments and to determine whether it should make changes to better serve those coping with mental illnesses. Further, in the near term, the Legislature should amend state law to encourage counties to use Mental Health Services Act (MHSA) funds to provide programs and services to those who are leaving LPS Act holds and who could benefit from continuing care in their communities. Such care could prevent subsequent involuntary treatment and reinforce the community care that the MHSA and the LPS Act intended people to receive.

The State Lacks a Comprehensive View of the Effect of Funding on the Lives of People With Mental Illnesses

Public accountability for the State's mental health funds currently relies on reporting tools that are disjointed and incomplete. As we detail in the Introduction, California has a largely county-based system for providing public mental health care to those living with serious mental illnesses. In fiscal year 2018–19, counties received more than \$7.5 billion in state and federal mental health dollars from three major types of funds: Medi-Cal, realignment, and MHSA.

We identified no source of consistent public reporting dedicated to the billions of dollars in annual realignment funds that counties can use to support those with serious mental illnesses and the outcomes of those services.

Although restrictions prevent counties from using some of these funds to provide involuntary treatment, counties can use any of the types of funds to provide a broad range of supportive services for those with mental illnesses—services that may ultimately reduce the need for involuntary holds. Further, counties combine fund types to provide those services—such as by using MHSA, realignment, and Medi-Cal funds to pay for the same service. However, existing reporting requirements do not provide decision makers and stakeholders with a clear view of the effectiveness of the State’s public mental health services. Without a statewide framework for determining spending and outcome information across all funding sources, the State will remain unable to fully and efficiently understand the effects of its investments in mental health services and, if necessary, make changes to better serve those who need critical services.

Most troubling is that we identified no source of consistent public reporting dedicated to the billions of dollars in annual realignment funds that counties can use to support those with serious mental illnesses and the outcomes of those services. As Figure 4 in the Introduction shows, counties received nearly \$3 billion in realignment funds that were available for mental health services in fiscal year 2018–19. State law governing realignment funds indicates that locally managed mental health programs should be cost-effective, should meet the needs of those with serious mental illnesses, and should be evaluated based on client outcomes. To hold counties accountable for meeting these goals, stakeholders and oversight agencies must know, at a minimum, the types of mental health services that counties fund with realignment dollars and the outcomes they achieve through those programs. Having information about services and outcomes would provide stakeholders a better understanding of whether counties’ spending—such as using realignment funds to pay for involuntary treatment—has effectively served individuals who need help managing their mental illnesses. Although we identified certain reports that include some information about realignment funds, each of these reports is limited; for instance, one is not designed for public reporting, and another does not include all realignment funds. We did not identify any public reports that specify how counties spent all of their realignment funds or how that spending contributed to improved outcomes for people.

The State reports some information about the mental health services that it funds through Medi-Cal, the single largest source of funds that counties receive for mental health services. Health Care Services has published reports—including legislatively mandated performance outcomes reports—that detail the types of services Medi-Cal supported, the amount of Medi-Cal funding used for each type of service, and some outcomes, such as how

many people eligible for Medi-Cal services received them and how promptly certain services were provided. Although relevant for the narrower purpose of explaining Medi-Cal funding and its functions, these reports are insufficient for providing a comprehensive understanding of county mental health systems because they are, by their nature, limited to the services for which Medi-Cal pays. For example, Medi-Cal reports do not contain information about care that some individuals treated under the LPS Act receive in state hospital facilities because Medi-Cal often does not cover this care. Moreover, the Medi-Cal reports we examined did not include outcomes that showed whether or how Medi-Cal services affected the individuals who received them.

MHSA funds come with the most comprehensive public reporting requirements among the major mental health funding sources, but these requirements are still insufficient for providing statewide accountability for mental health funding. State law and regulations require counties to publicly report information each year about programs they provide with MHSA funds, such as descriptions of the programs, the populations that programs serve, the amounts spent on each program, and certain outcomes. For example, for full-service partnership programs—through which counties must assign a case manager to each participant and offer a broad range of services—counties must report information that includes updates about participants' health, participants' living situations, and events of hospitalization or incarceration. However, similar to the limitations of the Medi-Cal reporting, this reporting is relevant for MHSA-funded programs but is insufficient for knowing the full range of counties' mental health spending.

In addition, current MHSA reporting requirements make it difficult for stakeholders to determine the balances of unspent MHSA funds that counties are maintaining, some of which may be available to provide additional services to those with mental illnesses. The three counties we reviewed have continued to maintain millions in unspent MHSA funds, a portion of which might benefit those with mental illnesses. As Table 2 shows, the counties' unspent funds after fiscal year 2018–19—excluding their prudent reserves, which state law places limits upon—represented between 73 and 175 percent of their respective 2018–19 MHSA revenues. Further, total balances of unspent funds increased over the preceding five-year period in each county we reviewed. The counties provided several explanations for maintaining these balances, including that MHSA revenue is volatile and that they have already allocated some of the unspent funds to planned uses in subsequent years. Nevertheless, it is important for stakeholders to be able to access information about the balances of unspent funds, some of which might be available to help those with mental illnesses.

The three counties we reviewed have continued to maintain millions in unspent MHSA funds, a portion of which might benefit those with mental illnesses.

In the past, counties uniformly reported their unspent funds in their annual MHSA revenue and expenditure reports (MHSA reports). In fact, in a report we issued in February 2018, we relied on information from those uniform revenue and expenditure reports to identify more than \$2.5 billion in unspent MHSA funds statewide. However, after we published that report, Health Care Services issued a template for revenue and expenditure reporting that no longer asked counties to provide their total unspent funds. Consequently, the MHSA reports no longer directly identify counties' unspent funds, and we had to perform analyses using data from the three counties' reports and from the State Controller's Office allocations of MHSA funds to counties to arrive at the totals that we show in Table 2.

Table 2
Health Care Services' Revenue and Expenditure Report Template Did Not Require the Three Counties to Disclose Their Millions in Unspent MHSA Funds

		BASED ON AUDITOR ANALYSIS			EASILY ACCESSIBLE IN HEALTH CARE SERVICES' REVENUE AND EXPENDITURE REPORT TEMPLATE?
		LOS ANGELES	SAN FRANCISCO	SHASTA	
	Total MHSA Revenue for Fiscal Year 2018–19	\$560.2 million	\$38.2 million	\$9.3 million	X
Cumulative Unspent Funds At End of Fiscal Year 2018–19	Community Services and Supports	\$451.9 million	\$13.5 million	\$7.1 million	X
	Prevention and Early Intervention	\$288.9 million	\$6.8 million	\$3.6 million	X
	Innovation	\$172.6 million	\$6.0 million	\$2.2 million	X
	Other*	\$66.5 million	\$1.7 million	–	X
	Total unspent funds, not including prudent reserves	\$980.0 million[†]	\$27.9 million	\$10.7 million[‡]	X
	Total unspent funds as a percent of revenue	175%	73%	114%	X
	Reported prudent reserve balances after fiscal year 2018–19	\$116.5 million	\$7.3 million	–	✓

Source: Estimates based on analysis of State Controller's Office allocations of MHSA funds to counties and information counties provided in their revenue and expenditure reports and in other documents.

Note: Because of rounding, the numbers for revenue and unspent funds may not add up exactly to the aggregated totals and percentages.

* Other unspent funds include Capital Facilities and Technological Needs funds and Workforce Education and Training funds.

[†] We shared our calculations of unspent funds with each county to obtain their perspective and consider whether any adjustments were necessary. Los Angeles expressed some concerns about the accuracy of our calculation but did not specify what about our methodology was incorrect or suggest a more appropriate calculation method.

[‡] Because Shasta did not report a prudent reserve balance, we calculated the maximum prudent reserve it could hold based on state law—roughly \$2.1 million—and subtracted that amount from its total unspent funds, which was approximately \$12.8 million.

Omitting the unspent fund totals from the MHSA reports decreases the transparency of the counties' use of these funds. According to the chief of its Policy, Monitoring, and Financing section, Health Care Services removed the reporting requirements for unspent funds because it wanted to include in the MHSA reports only information that was required by statute and necessary to calculate reversion—a process by which counties send certain unspent funds back to the State. However, state law establishes that one purpose of these reports is to identify unspent funds. Although the counties we reviewed did include some information about their unspent MHSA funds in other reports, these other reports are narrative in nature, can be hundreds of pages long, and do not always adhere to the same format in each county. In contrast, the MHSA reports have qualities that make them useful for transparency and accountability purposes. For example, state law requires counties to adhere to uniform accounting standards in preparing MHSA reports, and Health Care Services may withhold funds if counties do not submit the reports on time. By removing unspent funds from the MHSA reports, Health Care Services has made it more difficult for stakeholders to assess counties' financial positions, especially at a statewide level.

After it removed unspent funds information from the MHSA reports, Health Care Services adopted regulations that effectively prohibit the department from changing the content of the reports without revising its regulations. Therefore, the department would need to adopt revised regulations to once again include unspent funds in the MHSA reports. Health Care Services estimated that the earliest it could begin advancing revised regulations was July 2021. However, shortly before the planned release of this audit report, the department shared with us a new approach it planned to take that—if implemented—would result in publicly available information about unspent MHSA funds on the department's website. Health Care Services shared with us that it plans to begin posting information about unspent funds to its website starting in the late summer and early fall of 2020. If the department does not follow through with its planned actions, legislative action will be necessary to restore transparency to the use of MHSA funds.

Because of the limitations in reporting and accountability for each of the funding sources that we describe above, the State lacks a comprehensive view of counties' spending and outcomes in the area of mental health care. Legislators, oversight agencies, and other stakeholders should be able to understand holistically how counties spend billions of dollars in mental health funds and whether their spending improves the lives of Californians living with mental illnesses. Improving the quality of information that the State collects about mental health spending and outcomes would likely enhance discussions about the future of mental health care in California.

By removing unspent funds from the MHSA reports, Health Care Services has made it more difficult for stakeholders to assess counties' financial positions, especially at a statewide level.

By Reforming Mental Health Reporting Requirements, the State Could More Clearly Identify Spending and Increase Accountability for Outcomes

An overhaul of reporting requirements is necessary to understand how the billions of dollars that the State invests in its mental health care system affect those coping with mental illnesses. To facilitate a complete understanding of the cost and effectiveness of its mental health care system, the State needs a framework for collecting information about how counties spend mental health funds—across all major funding sources—and the extent to which that spending improves the lives of individuals with mental illnesses. Figure 11 is an outline for that framework, which we developed based on our work and on conversations with staff at the three counties, at Health Care Services, and at the Mental Health Services Oversight and Accountability Commission (Oversight Commission). This approach would provide clearer and more complete information to state and local policymakers and could assist them as they make decisions about how to direct future funding.

If the State is to realize the full benefits of restructuring its reporting framework, the approach it adopts must contain a few essential elements. As we previously indicate, the framework must include all major funding sources. Additionally, the framework should require

uniform reporting about specific, tailored categories that describe the types of services counties provide. Finally, an effective framework for monitoring mental health spending should contain information about outcomes of the specific programs that counties fund and also broader countywide and statewide outcomes.

The MHSA has established a precedent for counties' reporting their mental health spending to the State based on tailored categories. As we mention earlier, MHSA funds have the most comprehensive public reporting requirements among the major funding sources for mental health services. Counties must spend MHSA funds in the categories we show in the text box, and these categories are the basis for how counties annually report their MHSA spending totals. As a result, the categories are foundational to how the State and stakeholders understand the way that counties use MHSA funds. For instance, the Oversight Commission—which oversees the implementation of the MHSA—has published in its online fiscal reporting tool the amount of funds counties spend in each of the MHSA categories, and it has also aggregated this information to produce a statewide spending total for each category.

Counties Receive and Report on MHSA Funding Based on Three Key Categories

Community Services and Supports

- Mental health services and supports for children, transition-age youth, adults, and older adults. These include crisis services, full-service partnerships, housing programs, and outreach and engagement programs.

Prevention and Early Intervention

- Programs intended to prevent mental illnesses from becoming severe and disabling. These include programs for outreach, early intervention, linkage to treatment, and suicide prevention.

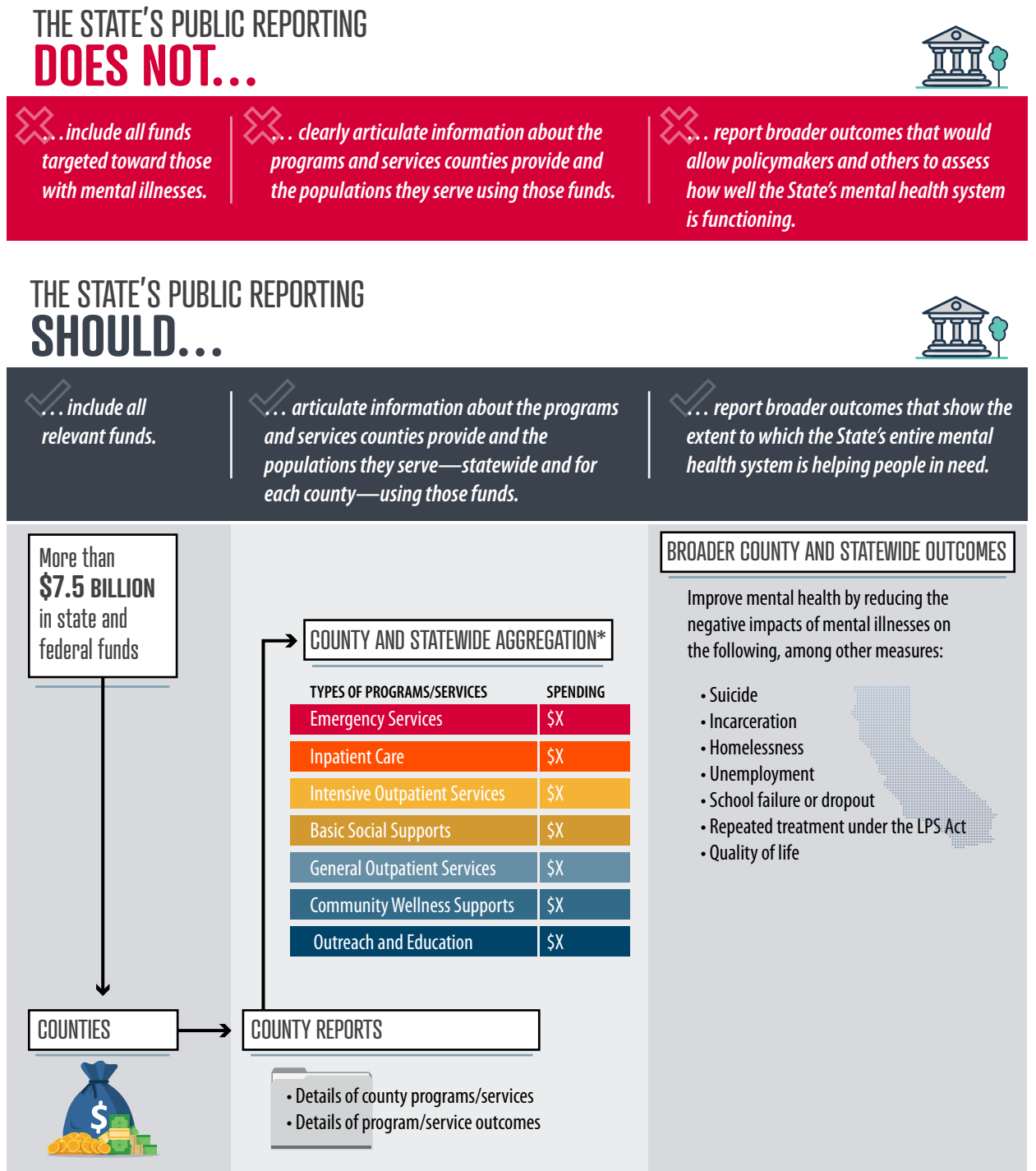
Innovation

- Innovative projects that counties implement for a defined time period to develop new best practices in mental health services and supports.

Source: State law.

Note: Counties can also use some Community Services and Supports funds for workforce education and training and for capital facilities and technological needs.

Figure 11
A Unified Framework for Reporting Spending and Outcomes Could Help Policymakers and Others Better Understand the State’s Mental Health System



Source: Analysis of state and county reporting tools for mental health funding and outcomes, discussions with staff at the three counties we reviewed, and conversations with staff at Health Care Services and the Oversight Commission.

* We developed these categories of programs and services based on our work and discussions with the counties we reviewed. We provide a more detailed version of this framework in Appendix B, including possible outcomes that counties could report for programs that fall under each category.

Without additional specificity about how counties spend funds within the broad MHSA categories, policymakers and other stakeholders will likely continue to encounter difficulties in assessing the State's current spending patterns and determining where it may be necessary to direct future resources.

Despite the prominence of the MHSA categories in statewide reporting, they are broad and do not convey specific information about how counties spend their funds. For example, about three-quarters of counties' MHSA funds fall under the Community Services and Supports category, which can include services ranging from crisis intervention to outreach and engagement efforts. As a result, the Oversight Commission's fiscal reporting tool shows that counties spent a total of \$1.1 billion on Community Services and Supports in fiscal year 2016–17, but the tool does not consistently identify how much of that \$1.1 billion supported specific types of services, such as crisis intervention or housing programs. Some detailed information about county programs is available in another tool on the Oversight Commission's website, but that tool primarily allows users to search for specific programs and is dependent on how counties report information. Without additional specificity about how counties spend funds within the broad MHSA categories, policymakers and other stakeholders will likely continue to encounter difficulties in assessing the State's current spending patterns and determining where it may be necessary to direct future resources. For instance, the current MHSA categories do not allow policymakers to assess the levels of spending on crisis intervention services and compare those to the levels of spending on services that could prevent people from experiencing a crisis in the first place.

As we show in Figure 11, the State could require counties to report their spending in more specific categories, such as inpatient care or intensive outpatient services. In contrast to the broader categories in the MHSA-related reporting, treatment categories such as these could provide a more specific overview of statewide mental health spending, as well as specific points of comparison between counties. For instance, policymakers and other stakeholders could identify the total amount of mental health funds that counties dedicate to emergency care statewide, and they could compare this amount to the total amount counties spend on outpatient services or basic social supports. Moreover, stakeholders could compare this spending information between different counties.

Further, an effective framework for monitoring mental health spending would also contain information about the outcomes of counties' specific programs. This level of reporting would capture important details that could help identify successful programs and inform prioritization of future investments. For instance, if a county with several different housing programs experienced overall improvement in assisting people with mental illnesses in finding and maintaining housing, program-specific outcomes could show which of the county's housing programs contributed most to the improvement.

Adopting a program-level outcome reporting requirement would be similar to requirements that the State has already adopted for certain MHSA-funded programs. For example, as we mention in the previous section, counties must report certain outcomes for their full-service partnership programs, such as updates about participants' health, living situations, and hospitalizations or incarcerations. Expanding this practice to require robust, program-specific reporting of outcomes for the full range of MHSA-funded programs, as well as programs that are not MHSA-funded, would provide a broader range of outcome data that decision makers could use to identify effective and ineffective programs. Doing so could provide, for instance, information about the capacity of treatment facility beds, which counties cannot pay for using MHSA funding if the beds are for long-term care. This information could include the availability of beds and the timeliness with which counties place individuals in appropriate treatment facilities. In Appendix B, we identify other possible program outcomes that counties could report.

The State would also benefit from a tool for collecting and reporting information about overarching indicators of mental health that are not limited to specific programs but may reveal how well the State is meeting the mental health needs of its residents. As we show in Figure 11, these indicators could include rates of suicide, percentages of incarcerated individuals who have mental illnesses, and rates of repeated LPS Act holds. The Oversight Commission has already contracted with researchers from the University of California, Los Angeles, to begin identifying and displaying statewide data related to homelessness, incarceration, suicide, and other metrics that state law identifies as negative outcomes that may result from untreated mental illnesses. The contract specifies that the research was to be completed by June 2020. The State could build upon this research to move toward a statewide tool for reporting high-level indicators of mental health that could demonstrate whether funding is improving the lives of Californians coping with mental illnesses.

The first step in overhauling reporting requirements as we describe should be to consider and make use of existing information to the extent possible. In addition to the work that the Oversight Commission has already begun, the State may be able to leverage other existing systems and research to develop the framework we recommend. For example, Health Care Services maintains a data system that the Department of Mental Health and other entities developed to collect client-level information—such as the services individuals receive, their current employment statuses, and their living arrangements—for people who receive certain county-provided mental health services. These data could show, for example, whether people receiving certain county services have housing or employment. Although Health Care Services uses

A tool for collecting and reporting information about overarching indicators of mental health that are not limited to specific programs may reveal how well the State is meeting the mental health needs of its residents.

the data system for purposes such as reporting information to the federal government, the State currently lacks a statewide dashboard or other tool that consolidates and publicly reports outcomes information from the data system. When we asked about the system, the analytics and research methods section chief at Health Care Services indicated that its data could conceivably support a statewide reporting tool for outcomes.

If the State established the reporting framework we describe above without also updating existing reporting requirements, it would place an additional administrative burden on counties. In particular, the reporting framework we outline would likely overlap with the existing requirements for counties to report certain spending and outcomes information for MHSA-funded programs. Considering the amount of overlap between the reforms we recommend and the requirements that currently exist for the MHSA, it would be most efficient to couple any new requirements with simultaneous changes to MHSA reporting. For example, the reporting that counties would produce under the new framework could expand upon or replace existing MHSA reports. Because of the need to reduce the administrative burden of a new reporting system and because the Oversight Commission already holds key MHSA oversight responsibilities and has taken measures to analyze and display spending and outcomes information related to MHSA reporting—which is the reporting that is closest to our recommended model—it would make sense for the Legislature to assign the Oversight Commission primary responsibility for managing and implementing the new reporting framework that we recommend.

It would make sense for the Legislature to assign the Oversight Commission primary responsibility for managing and implementing the new reporting framework that we recommend.

Changes to the MHSA Could Ensure That Counties Leverage Those Funds to Provide Critical Services for Individuals Who Need Them Most

Policymakers have raised the possibility of altering how counties spend MHSA funds. At a December 2019 hearing, members of the Legislature were interested in discussing whether the MHSA should be reformed and whether the State should invest more resources in the Prevention and Early Intervention funding category. In addition, in his February 2020 State of the State address, the Governor indicated that reforms should focus MHSA funds on specific populations, such as individuals experiencing homelessness or involved in the criminal justice system. The solution we outline in this chapter—to collect spending and outcomes information for all major mental health funding sources—could provide a useful context for decisions about redirecting funding or adding funding to the State’s mental health system. However, in the near term, the State should take action to ensure that counties use MHSA funds

to provide services to people who have left short-term holds or conservatorships, which is a population our review identified as inadequately served.

To better serve individuals who have been on LPS Act holds and experience serious mental illnesses, the Legislature should identify them as a population that MHSA funds must target and require counties to use MHSA funds to connect that population to community-based care. Individuals who have been on short-term involuntary holds have experienced mental health crises, and the results we present in Chapter 2 show that these individuals sometimes experience multiple crises in their lifetime. Nevertheless, as we discuss in Chapter 1, Los Angeles and San Francisco—the largest counties we reviewed—have often not ensured that people leaving short-term holds receive ongoing care. Although we focused our review on three counties, providing community-based care to individuals who have been held involuntarily is an issue of statewide importance and is consistent with the LPS Act's intent of ending the inappropriate, indefinite, and involuntary commitment of individuals with mental illness.

Because MHSA funding is intended to support community-based services and not more restrictive treatment, we believe it would be consistent with the purpose of the MHSA if the Legislature required counties to spend some MHSA funding to support a stated goal of connecting all individuals who are leaving LPS Act holds—and who could benefit from subsequent services—with those services. Although the MHSA permits counties to spend MHSA funds for this purpose under current law, requiring them to do so would ensure that all counties make concerted efforts to provide services to an important and underserved population and report about those services to the public. For example, linkage to treatment could reasonably be attributed to both the Community Services and Supports and the Prevention and Early Intervention categories of MHSA funding—the latter of which includes linkage to treatment programs for individuals with serious mental illnesses—that together compose 95 percent of counties' MHSA revenues. The Legislature should therefore specify that counties can use either of these funding categories to meet this goal.

If it made individuals who have been treated under the LPS Act a population for MHSA funds to target, the Legislature would also position those funds to provide the expanded outpatient care that we recommend in this report. In Chapter 2, we note that fewer than a third of California's counties have adopted assisted outpatient treatment programs and that eligibility requirements for this treatment are a barrier to participation for some who would benefit from the program; as a result, we recommend changes that would promote wider use of assisted outpatient treatment. This wider use

If it made individuals who have been treated under the LPS Act a population for MHSA funds to target, the Legislature would also position those funds to provide the expanded outpatient care.

would likely help to reduce the number of individuals who cycle through crisis care when they are held multiple times for involuntary treatment or who experience multiple conservatorships. Further, the assisted outpatient treatment approach is consistent with the aim of MHSA and of the LPS Act to serve individuals in their communities and not in institutional settings. This linkage makes MHSA funding a prime vehicle to fund assisted outpatient treatment—including court-ordered assisted outpatient treatment, for which state law already allows counties to use MHSA funds—and the counties we reviewed each have reported using MHSA funds for assisted outpatient treatment programs. More broadly, any counties that fund these programs—including any expansions of assisted outpatient treatment resulting from our recommendation in Chapter 2—could use the programs to provide the continuing care we describe in this section for eligible individuals who have left LPS Act holds. By defining these individuals as a population for MHSA funds to target and by requiring counties to connect them to care such as assisted outpatient treatment, the Legislature could ensure that counties are providing community-based treatment and services to those who are among the most in need.

Recommendations

Legislature

To increase the accountability for and effectiveness of the counties' use of mental health funds, the Legislature should amend state law to do the following:

- Assign primary responsibility to the Oversight Commission for comprehensive tracking of spending on mental health programs and services from major fund sources and of program- and service-level and statewide outcome data. The Legislature should require the Oversight Commission to consult with state and local mental health authorities to carry out this responsibility. The Legislature should also require the Oversight Commission to explore available data and information when developing this reporting framework, and it should grant the Oversight Commission authority to obtain relevant data and information from other state entities.
- Require the Oversight Commission to develop categories of mental health programs and services, similar to those we present in Figure 11, that are tailored to inform assessments of spending patterns. The Legislature should subsequently require counties

to report to the Oversight Commission their expenses in each of these categories as well as their unspent funding from all major funding sources.

- Require counties to report to the Oversight Commission, in a format prescribed by the commission, program- and service-level outcomes that enable stakeholders to determine whether counties' use of funds benefits individuals living with mental illnesses.
- Direct the Oversight Commission to develop statewide measurements of mental health—such as those we highlight in Figure 11—and report publicly about those measurements annually so that stakeholders and policymakers can assess the progress the State is making in addressing mental health needs.
- Require the Oversight Commission to work with counties and other state and local agencies as necessary to use the information it collects to improve mental health in California.

To better serve individuals who are among the most in need of critical, community-based treatment and services, the Legislature should amend state law to do the following:

- Identify those who have left LPS Act holds and who experience serious mental illnesses as a population that MHSA funds must target.
- Establish a goal in the MHSA of connecting all such individuals to the community-based programs and services that they would benefit from—such as assisted outpatient treatment—and require counties to fund efforts to link these individuals to those programs and services. The Legislature should also establish that a goal of providing those programs and services is to reduce the number of repeated involuntary holds or conservatorships that occur.
- Specify that counties can use any portion of their MHSA funds for this purpose as long as they comply with other statutory and regulatory requirements.

If Health Care Services does not follow through with its plan to provide, on its website, information about each county's unspent MHSA funds, the Legislature should amend state law to explicitly require counties to include information about their balances of unspent MHSA funds in their MHSA annual revenue and expenditure reports.

We conducted this performance audit in accordance with generally accepted government auditing standards and under the authority vested in the California State Auditor by Government Code 8543 et seq. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on the audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,



ELAINE M. HOWLE, CPA
California State Auditor

July 28, 2020

Appendix A

Scope and Methodology

The Joint Legislative Audit Committee (Audit Committee) directed the California State Auditor to develop and verify information related to the implementation of the LPS Act by Los Angeles and two additional counties. We selected San Francisco and Shasta as the additional counties for review. Table A below lists the objectives that the Audit Committee approved and the methods we used to address them.

Table A
Audit Objectives and the Methods Used to Address Them

AUDIT OBJECTIVE	METHOD
<p>1 Review and evaluate the laws, rules, and regulations significant to the audit objectives.</p>	<p>Reviewed and evaluated relevant federal and state laws, rules, regulations, and best practices related to the LPS Act, including laws related to the broader mental health systems within which counties implement involuntary holds.</p>
<p>2 Review the statewide oversight of the implementation of the LPS Act.</p>	<ul style="list-style-type: none"> • Documented and assessed the roles and responsibilities of Health Care Services, State Hospitals, the Judicial Council, Justice, and the Oversight Commission by evaluating their oversight responsibilities and relevant data. • Documented Health Care Services' rulemaking history related to the LPS Act and other relevant mental health issues for the last five fiscal years. • Documented procedures related to Health Care Services' approval and inspection of county treatment facilities and inspection and certification of facilities that provide Medi-Cal specialty mental health services. • Evaluated State Hospitals' LPS Act waitlist projections and its usage planning for state facility capacity. • Determined that the Judicial Council provides training and educational resources for judges who hear LPS Act conservatorship cases. • Evaluated Justice's process for monitoring and maintaining data relevant to the LPS Act by assessing how it tracks treatment facility data. • Interviewed agency staff about their roles, responsibilities, and perspectives.
<p>3 By county and for each of the most recent three years, determine the following:</p> <ol style="list-style-type: none"> a. The number of individuals placed under initial involuntary holds, the referral sources for those holds, and the number of individuals placed under repeated initial holds. b. The number of individuals placed under subsequent holds. c. The number of individuals placed into new and renewed LPS conservatorships and the referral source for those conservatorships. d. The average length of LPS conservatorships. e. The number of terminated LPS conservatorships and the reasons for the termination. 	<ul style="list-style-type: none"> • Obtained Justice's mental health holds data to determine, for fiscal years 2014–15 through 2018–19, the number of individuals placed on 72-hour holds, repeated 72-hour holds, 14-day holds, and conservatorships. • Because of statewide data limitations, conducted a case file review to determine the referral sources for a selection of 30 72-hour holds. • Analyzed Justice's data for all fiscal years available to identify the number of individuals placed on holds during fiscal years 2014–15 through 2018–19 who had been placed on repeated holds during their lifetime. Justice's data are limited to individuals placed on involuntary holds because they were determined to be dangerous to themselves or others. • Because of statewide data quality issues, completed manual and automated data identification of duplicate records for the three counties in the audit to ensure, to the extent possible, accuracy in calculating the number of repeated holds per individual. • Because of statewide data limitations, conducted a case file review to determine the referral sources, average length of conservatorships, and reasons for termination for a selection of 60 conservatorship cases.

continued on next page ...

AUDIT OBJECTIVE	METHOD
<p>4 Assess the counties' implementations of the LPS Act for the last three years and compare the counties to one another by reviewing at least the following:</p> <p>a. The counties' definitions of the criteria for involuntary treatment holds and whether each county has consistently applied its definitions.</p> <p>b. The counties' criteria for placing individuals into LPS conservatorships and making least-restrictive-environment determinations and whether the counties have consistently followed these criteria.</p>	<ul style="list-style-type: none"> • Evaluated each county's process for placing individuals on short-term holds, including how it interpreted criteria and whether it applied those criteria consistently, and compared the three counties' processes. • Used county, law enforcement, and Justice data to select 10 72-hour hold cases, 10 14-day hold cases, and 20 cases in which 72-hour holds might have been placed but were not in each county from fiscal years 2016–17 through 2018–19. • Evaluated the selected cases to assess why the holds were placed, the start and stop times of the holds, the histories of the individuals, and the connection to subsequent treatment. • Evaluated each county's process for placing individuals on conservatorships, including how it determined who should be placed on conservatorship and how it ensured the confidentiality of sensitive information. • Used county data to select 20 conservatorship cases from each county for case file review. We selected conservatorships that ended during fiscal years 2016–17 through 2018–19, including up to five cases per county involving individuals who had been found incompetent to stand trial. We verified that the county records we used to make our selection of case files were sufficiently complete for our purposes. • Evaluated superior court processes by reviewing judicial orders and transcripts granting and terminating conservatorship for elements such as the evidence used to support the final decisions and whether individuals placed on conservatorships retained their right to consent to or refuse medications. • Documented the placements of individuals on conservatorships and evaluated the extent to which counties provided care in the least restrictive setting appropriate to individuals' needs. To do so, we reviewed counties' policies and processes for placing individuals in appropriate levels of care and whether individuals moved from more restrictive to less restrictive levels of care during conservatorships.
<p>5 Assess whether any differences between county approaches to involuntary holds, conservatorships, or the associated care provided to individuals should be addressed through changes to state law or regulation.</p>	<ul style="list-style-type: none"> • Documented county policies and assessed applications of policies through a review of case files to determine whether counties implemented involuntary holds and conservatorships consistently. • Reviewed laws in other states to identify possible best practices or potentially beneficial changes to state law or regulation. • Interviewed nonprofit stakeholders to identify concerns regarding treatment and rights protections for individuals placed on involuntary holds and conservatorships.
<p>6 Determine how the counties fund their implementations of the LPS Act and whether access to funding is a barrier to the implementation of the LPS Act.</p>	<ul style="list-style-type: none"> • Evaluated the Medi-Cal process and reimbursements for psychiatric patients to identify possible barriers to treatment and mental health coverage for Medi-Cal beneficiaries. • Documented or determined each county's unspent MHSA fund balance and evaluated the county's stated reasons for maintaining that balance. • Documented and assessed existing statewide reporting requirements for mental health funding and outcomes.

AUDIT OBJECTIVE	METHOD
<p>7 Assess the availability of treatment resources in each county and, to the extent possible, determine whether there are barriers to achieving the intent of the LPS Act. In doing so, at the minimum, consider the number of LPS facilities in each county and the availability of rehabilitative programs during and after conservatorships.</p>	<ul style="list-style-type: none"> • Determined the range of services each county has available to individuals treated through the LPS Act. • Assessed the extent to which counties have connected individuals who have been on LPS Act holds to assisted outpatient treatment and full-service treatment programs. Relied on records kept by counties that indicated the enrollment in these programs. Reviewed the completeness and accuracy of these records by comparing to enrollment data held by Health Care Services. Although we identified some errors in this review that could affect the precision of the numbers we present in this report, there is sufficient evidence overall to support the findings and conclusions we present in this report. • Obtained assisted outpatient treatment and full-service treatment enrollment data from the counties to calculate various three-day hold statistics for individuals enrolled in assisted outpatient treatment and full-service partnership programs. • Evaluated barriers to implementation of assisted outpatient treatment in each county. • Documented facilities designated for evaluation and treatment under the LPS Act in each county and in a selection of three additional counties. • Evaluated Los Angeles’s treatment facility referral and waitlist tracking logs to identify barriers to placement of individuals receiving services through the LPS Act. • Evaluated existing reports regarding oversight, cost, and outcomes for assisted outpatient treatment and full- service partnership treatment approaches. • Documented and assessed State Hospitals’ admissions and discharge practices, admissions waitlist, facility inventory, and recent and possible future need for capacity expansion.
<p>8 Review and assess any other issues that are significant to the audit.</p>	<p>Documented contextual information and background statistics for issues related to mental illness, including homelessness, incarceration, and substance abuse.</p>

Source: Analysis of Audit Committee’s audit request number 2019-119, state law, and information and documentation identified in the column titled Method.

Assessment of Data Reliability

The U.S. Government Accountability Office, whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of the computer-processed information that we use to support our findings, conclusions, and recommendations. In performing this audit, we relied on Justice’s mental health hold data to calculate various statistics, including the number of repeat holds, in Los Angeles, San Francisco, and Shasta. To evaluate these data, we reviewed existing information about the data, interviewed agency officials knowledgeable about the data, and performed electronic testing of the data. We determined that Justice’s data does not consistently track a unique person identifier that can be used to identify multiple holds for a single individual. Further, we found that medical providers and courts had sometimes submitted mental health hold data to Justice using different variations of individuals’ names. To help account for these issues, we removed duplicate hold records and performed manual and automated deduplication work to group holds by person. However, we were unable to uniquely identify individuals related

to 5 percent of the holds during our audit period. As a result, we found these data are of undetermined reliability for our purposes. Although these issues may affect the precision of the numbers we present, there is sufficient evidence in total to support our findings, conclusions, and recommendations.

We also obtained State Hospitals' pre-admission data to determine the number of people on its waitlist and how long they had been waiting. To evaluate these data, we interviewed agency officials knowledgeable about the data and performed electronic testing of the data. However, we did not perform accuracy and completeness testing of the data because source documents are located at various locations throughout the State, making such testing cost-prohibitive. As a result, these data are of undetermined reliability. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our findings, conclusions, and recommendations.

Appendix B

Detailed Proposal for Reporting Framework

Counties provide a range of programs and services to individuals with mental illnesses. However, as we discuss in Chapter 3, no reporting framework currently exists that makes it easy for stakeholders to understand the types of services counties provide, how they fund those services, and the impacts of those services on people's lives. In the course of our review of three counties' mental health systems, we created an example of a framework that would address that issue, which we present in detail in Table B. We based our framework on the services that counties provide, with the goal of categorizing those services simply but in a way that allows for useful comparisons between the various categories. We believe this kind of framework could help the State collect and report information from counties that would allow stakeholders—including the Legislature—to better evaluate mental health spending and outcomes statewide.

Table B
Example Reporting Framework for County Mental Health Programs and Services

COMPONENTS	EXAMPLES OF PROGRAMS AND SERVICES	POSSIBLE PROGRAM AND SERVICE OUTCOMES
<p>Emergency Services Short-term emergency or crisis services.</p>	<ul style="list-style-type: none"> • Urgent care and emergency room services. • Mobile crisis response teams. • Law enforcement and mental health teams. 	<ul style="list-style-type: none"> • Response time of first responders. • Emergency room wait time and length of stay. • Frequency and timeliness of linkage to subsequent services.
<p>Inpatient Care Extended treatment/care in facility settings.</p>	<ul style="list-style-type: none"> • Services in state hospital facilities. • Services in general acute hospitals or acute psychiatric hospitals. • Services in residential care facilities. 	<ul style="list-style-type: none"> • Availability of beds/timeliness of placement by facility type. • Medication compliance. • Frequency and timeliness of linkage to subsequent services.
<p>Intensive Outpatient Services Community-based programs with individualized support and case management that coordinate care for clients with serious mental illnesses.</p>	<ul style="list-style-type: none"> • Full service partnership programs that include personal case managers. • Assisted outpatient treatment programs that include personal case managers and low staff-to-client ratios. • Intervention treatment programs for schizophrenia and early psychosis. 	<ul style="list-style-type: none"> • Population served and population with unmet needs. • Medication compliance. • Clients' health status and other quality-of-life measures. • Clients' incidences of hospitalization, incarceration, and other negative outcomes.
<p>Basic Social Supports Community-based programs and services primarily focused on meeting basic needs, such as food, clothing, and shelter.</p>	<ul style="list-style-type: none"> • Supportive housing and shelter programs. • Drop-in centers providing temporary safety, food, clothing, and hygiene facilities, as well as linkages to mental health services and supports. 	<ul style="list-style-type: none"> • Population served and population with unmet needs. • Average length of stay (for housing and shelter). • Frequency and timeliness of linkage to concurrent or subsequent services.
<p>General Outpatient Services Medical services and supports, such as evaluation and medication, provided on an outpatient and as-needed basis.</p>	<ul style="list-style-type: none"> • Drop-in and appointment-based programs that provide evaluations, pharmaceuticals, and placements into treatment programs. • Health centers that provide a variety of services, such as assessments, medication management, and psychotherapy sessions. 	<ul style="list-style-type: none"> • Population served and population with unmet needs. • Frequency and timeliness of linkage to concurrent or subsequent services. • Medication compliance (when applicable). • Clients' health status and other quality-of-life measures (when applicable). • Clients' incidences of hospitalization, incarceration, and other negative outcomes (when applicable).
<p>Community Wellness Supports Social programs and supports available in the community to improve individuals' wellness.</p>	<ul style="list-style-type: none"> • Wellness centers. • Peer support and resource centers • Programs that offer social support groups and other wellness-based activities, as well as referrals to services and supports such as food, clothing, and medical attention. 	<ul style="list-style-type: none"> • Population served and population with unmet needs. • Frequency and timeliness of linkage to concurrent or subsequent services. • Client-reported wellness and satisfaction with programs and supports.
<p>Outreach and Education Outreach, education, and training to provide information about available services; educate staff and community members; and encourage well-being.</p>	<ul style="list-style-type: none"> • Stigma reduction programs. • Implicit bias forums/trainings. • Parenting programs aimed at enhancing parents' knowledge, skills, and confidence as a preventive measure for their children. • Suicide prevention campaigns to inform the community about related resources. 	<ul style="list-style-type: none"> • Population served or affected by outreach and education efforts. • Impact of efforts on individuals' engagement with treatment. • Community awareness of and attitudes toward available services.

Source: Analysis of county documents such as MHPA reports and continuums of care, state law, other documents about the range of mental health services available, and discussions with county and state staff.

Appendix C

Additional Data About Involuntary Holds and Conservatorships

The Audit Committee asked us to provide a variety of summary information related to involuntary holds and conservatorships in the counties we reviewed. The following tables summarize additional or more detailed results of our review of data related to the involuntary holds and conservatorships we discuss throughout the report. Because statewide data on conservatorships are limited, we provide information about conservatorship referrals, durations, and terminations based on our review of 60 case files in the three counties that we reviewed during this audit.

Table C.1
 The Number of Involuntary Holds per Fiscal Year Has Generally Increased

TYPE OF INVOLUNTARY HOLD	2014-15	2015-16	2016-17	2017-18	2018-19
Los Angeles					
72-hour-hold	71,018	72,508	73,830	80,047	81,505
14-day-hold	15,828	14,156	15,038	15,497	15,820
Conservatorship	4,389	4,919	4,660	4,623	4,698
San Francisco					
72-hour-hold	4,524	4,086	3,718	4,033	3,837
14-day-hold	448	580	592	798	897
Conservatorship	531	531	525	537	601
Shasta					
72-hour-hold	631	581	504	403	670
14-day-hold	148	220	235	246	310
Conservatorship	60	81	86	69	94

Source: Analysis of Justice's mental health holds data.

Table C.2
Many Individuals Were Placed on Multiple Involuntary Holds

	INDIVIDUALS WITH AT LEAST ONE HOLD OF THIS TYPE	INDIVIDUALS WITH ONLY ONE HOLD OF THIS TYPE	INDIVIDUALS WITH MORE THAN ONE HOLD OF THIS TYPE	AVERAGE NUMBER OF HOLDS FOR INDIVIDUALS WITH MULTIPLE HOLDS OF THIS TYPE
72-Hour Hold				
Los Angeles	166,447	94,425 (57%)	72,022 (43%)	6.2
San Francisco	14,010	9,647 (69%)	4,363 (31%)	4.3
Shasta	2,206	1,701 (77%)	505 (23%)	2.8
14-Day Hold				
Los Angeles	57,130	33,574 (59%)	23,556 (41%)	4.1
San Francisco	3,428	2,401 (70%)	1,027 (30%)	2.9
Shasta	962	763 (79%)	199 (21%)	2.5

Source: Analysis of Justice's mental health holds data.

Note: This analysis includes the lifetime total number of holds for individuals with a hold or conservatorship from fiscal years 2014–15 through 2018–19. However, we excluded 5 percent of the holds in our audit period from this analysis because we could not associate each of these holds with a unique individual for reasons such as a blank date of birth or a likely fictitious name.

Table C.3
Most Individuals Placed on Conservatorship Were Subject to Multiple Conservatorship Orders

	INDIVIDUALS WITH AT LEAST ONE CONSERVATORSHIP ORDER*	INDIVIDUALS WITH ONLY ONE CONSERVATORSHIP ORDER	INDIVIDUALS WITH MORE THAN ONE CONSERVATORSHIP ORDER	AVERAGE NUMBER OF CONSERVATORSHIP ORDERS FOR INDIVIDUALS WITH MULTIPLE CONSERVATORSHIP ORDERS
Los Angeles	7,242	1,324 (18%)	5,918 (82%)	5.5
San Francisco	813	160 (20%)	653 (80%)	4.4
Shasta	152	40 (26%)	112 (74%)	3.7

Source: Analysis of Justice's mental health holds data.

Note: This analysis includes the lifetime total number of conservatorship orders for individuals with a hold or conservatorship from fiscal years 2014–15 through 2018–19. Conservatorship orders include orders renewing a conservatorship after one year and orders establishing new conservatorships.

* A small percentage of these individuals did not experience a conservatorship from fiscal years 2014–15 through 2018–19, but experienced at least one conservatorship in their lifetime. Nevertheless, these individuals continued to interact with the mental health system by being placed on involuntary holds during our audit period.

Table C.4
Designated Professionals at Treatment Facilities and Correctional Facilities Made the Referrals for the Conservatorships We Tested

	REFERRALS FROM TREATMENT FACILITIES	REFERRALS FROM CORRECTIONAL FACILITIES
<i>Los Angeles</i>	14	6
<i>San Francisco</i>	16	4
<i>Shasta</i>	18	2

Source: Analysis of 60 conservatorship case files.

Note: State law allows designated professionals at treatment facilities and county jails to recommend conservatorships for gravely disabled individuals. We deliberately included some cases involving the criminal justice system in our review of 20 case files from each county. Therefore, the information presented here is not necessarily indicative of the sources of conservatorship referrals generally.

Table C.5
The Conservatorships We Tested Lasted About Three Years on Average

	AVERAGE LENGTH OF CONSERVATORSHIP
<i>Los Angeles</i>	2 years and 8 months
<i>San Francisco</i>	3 years and 6 months
<i>Shasta</i>	3 years and 3 months

Source: Analysis of 60 conservatorship case files.

Table C.6
Except in Los Angeles, Most Conservatorships We Tested Ended When Individuals Were Able to Provide for Their Basic Needs

	COUNTY OR COURT DETERMINED THE INDIVIDUAL WAS NO LONGER GRAVELY DISABLED	INDIVIDUAL LEFT TREATMENT FACILITY WITHOUT AUTHORIZATION	CONSERVATORSHIP TERMINATED BECAUSE COURT COULD NOT PROCEED*
<i>Los Angeles</i>	8	5	7
<i>San Francisco</i>	14	5	1
<i>Shasta</i>	18	2	0

Source: Analysis of 60 conservatorship case files.

* The absence of a doctor's testimony, which we discuss in Chapter 1, was the most frequent reason why courts could not proceed. In two other cases, the courts could not proceed because of individuals' specific circumstances rather than because of a systemic problem.

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July 2020

XAVIER BECERRA
Attorney General

State of California
DEPARTMENT OF JUSTICE



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July 10, 2020

Elaine Howle
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Re: Draft Audit Report – 2019-119; County Implementation of the Lanterman-Petris-Short (LPS) Act

Dear Ms. Howle,

The Department of Justice (DOJ) appreciates the opportunity to review the above-mentioned draft audit report. As the audit suggests, DOJ's use of the mental health records is very limited to the purpose of determining someone's eligibility to purchase or possess firearms and/or ammunition. As discussed during the audit, rather than query the mental health data from DOJ on a daily basis, the Department of Health Care Services (DHCS) may be best positioned to also receive the data directly from the mental health treatment facilities.

Furthermore, DOJ does not currently have the systematic capabilities in place to make mental illness information that treatment facilities report to DOJ, available to the DHCS. In order to comply with the recommendations as outlined in the audit report, DOJ would need to modify the pertinent automated mental health reporting systems. Express authority from the Legislature, along with additional employee and financial resources is needed to implement the recommendation.

If you have any questions or concerns regarding this matter, you may contact me at the telephone number listed above.

Sincerely,

A handwritten signature in black ink, appearing to read "Luis Lopez".

LUIS LOPEZ, Director
Bureau of Firearms

For **XAVIER BECERRA**
Attorney General

cc: Sean McCluskie, Chief Deputy to the Attorney General
Edward Medrano, Chief, Division of Law Enforcement
Joe Dominic, Chief, California Justice Information Services
Chris Prasad, CPA, Director, Office of Program Oversight and Accountability

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July 2020

State of California – Department of State Hospitals

Gavin Newsom, Governor

Office of the Director
 1600 9th Street, Room 151
 Sacramento, California 95814
www.dsh.ca.gov



July 10, 2020

Elaine M. Howle, California State Auditor*
 Auditor of the State of California
 621 Capitol Mall, Suite 1200
 Sacramento, CA 95814

Subject: Department of State Hospitals Response to draft report concerning Lanterman-Petris Short Act.

Dear Ms. Howle:

Thank you for the time and attention your auditors spent with us at the Department of State Hospitals (DSH) in assessing our implementation of the Lanterman-Petris-Short (LPS) Act.

We appreciate the recognition of the challenges in implementing the LPS Act considering our resources and the growing number of persons with serious mental illness throughout the state of California in need of conservatorship.

Although not required, we did want to provide some responses clarifying a few points raised in the draft report.

1. On page 2, the report finds that the main reason LPS patients were waiting for an average of one year for treatment is because of a shortage of available treatment beds at DSH. This assumes that patients on our waitlist can only be treated at DSH, which is the most restrictive level of care. LPS patients on the waitlist can be treated in other settings. The report does not reflect a consideration as to whether some of these patients could be more appropriately treated in a less restrictive environment, to be identified by their conservator or guardian. ①
 2. On page 15, the report finds that due to placement on a waitlist, DSH has failed to provide adequate care to those patients on our waitlist. While those patients are waiting for treatment at DSH, it is also important to note that placement at DSH is only one option for treatment. The patient's conservator or public guardian, who is statutorily responsible for ensuring adequate care and charged with finding appropriate placement options even while patients are on the DSH waitlist, can pursue active investigation and consideration if less restrictive placement options are clinically appropriate, and available. ②
3. ③

“Caring Today for a Safe and Healthy Tomorrow”

* California State Auditor's comments begin on page 81.

July 10, 2020
(Letter to: Elaine M. Howle, California State Auditor)
Page 2 of 2

3. On page 15, the report states that we do not have sufficient treatment capacity for individuals needing services under the LPS Act due to limited space, rapidly increasing referrals, and the requirements we treat patients committed to DSH through the criminal justice system. However, it is necessary to recognize factors contributing to the waitlist. Importantly, DSH identifies a significant number of LPS Act patients currently in our care who we have found clinically appropriate to step down to a less restrictive placement but whom the counties have not transferred to such a setting. We provided the audit team data as to the number of these patients, and how long they have been waiting to be discharged by the county to a lower level of care. A failure to move discharge eligible patients is another factor that limits our treatment capacity to serve LPS patients on our waitlist.
- ④ 4. On page 16, the report notes two LPS Act patients have waited over three years to be admitted for treatment at DSH. Regarding the first patient, the County declined the bed initially offered due to the medical needs of the patient. For the second patient - the County chose to prioritize for placement ahead of this individual seven other patients for treatment at DSH that were placed on the waitlist after this patient.
- ⑤ 5. On page 19, the second paragraph refers to capacity to treat "involuntary holds." DSH treats conservatorship patients, not "involuntary holds."

We share and appreciate the concern for LPS Act patients and welcome further conversations on how best to address these patients' needs.

Sincerely,
Stephanie Clendenin
Director

cc: Secretary Mark A. Ghaly, MD, MPH, California Health and Human Services Agency

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE DEPARTMENT OF STATE HOSPITALS

To provide clarity and perspective, we are commenting on State Hospitals' response to our audit. The numbers below correspond to the numbers we have placed in the margin of State Hospitals' response.

We provided State Hospitals a redacted copy of the final draft of our audit report. Accordingly, the page numbers in State Hospitals' response do not correspond to the page numbers in the final report.

①

Our report acknowledges the span of treatment options available to individuals on conservatorships, but also recognizes that some of those individuals require care in a state hospital facility. As we note on page 25, the fact that courts and counties have determined that waitlisted individuals require care in a state hospital facility indicates that they need the level of care provided in those facilities.

②

When we shared our final draft report text with State Hospitals, to protect the confidentiality of our report, we shared only the portions of the report directly related to State Hospitals. The full text of our report makes clear that individuals who are waiting for space in a state hospital facility sometimes receive inadequate care while they wait. For example, on page 24, we summarize that Los Angeles's records showed several instances in which individuals who were waiting for a bed in a state hospital facility were a risk to themselves or those around them while in lower levels of care.

③

After receiving State Hospitals' response we amended our report text to describe the data it shared with us. These data do not change our conclusion that the predominate factor affecting the availability of treatment space at state hospital facilities is the legal mandate that requires State Hospitals to serve individuals involved with the criminal justice system.

④

To avoid any potential for confusion, we have amended the text on page 25 to make clear that the individuals who receive care have been placed on a conservatorship.

⑤

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DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
Director

Gregory C. Polk, M.P.A.
Chief Deputy Director

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Chief Medical Officer

July 10, 2020

Elaine M. Howle, State Auditor*
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Subject: *"Implementation of the Lanterman-Petris-Short Act,"* Report No. 2019-119, July 2020

INTRODUCTION

The Los Angeles County Department of Mental Health (LACDMH) appreciates the opportunity to respond to the "Implementation of the Lanterman-Petris-Short (LPS) Act" Audit No. 2019-119 by the California State Auditor's Office (State Auditor). LACDMH is well versed in factors related to the LPS Act and has worked for over a year to provide solid solutions to modernize the Act to meet the growing needs of those in Los Angeles County and throughout California.

LACDMH RECOMMENDATIONS

On June 3, 2019, the Joint Legislature Audit Committee requested the State Auditor to conduct an audit on the implementation of the LPS Act. The **express goal** of the audit was to "examine the application of the LPS laws throughout the state to determine if any updates, clarifications or improvements [were] needed to ensure the equal application of California's mental health commitment procedures." Its scope was limited to examining the LPS process, methods of involuntary treatment, availability of treatment resources, and access to funding as potential barriers to the implementation and/or improvement of the Act.

① While the State Auditor made some recommendations to improve and expand the use of Assisted Outpatient Treatment, it failed to conduct a deep analysis of LPS laws to guide the Legislature in its long-standing desire to reform the LPS Act, specifically its mental health civil commitment process. Rather, its focus shifted to county specific issues regarding the quality of mental health services and court procedures as well as the on-going myth of unspent county Mental Health Services Act (MHSA) funds.

② During the audit, LACDMH provided ample recommendations for legislative changes relevant to involuntary commitment but these were not included in the final audit response. In addition to a few others, LACDMH proposes those legislative changes here.

- ③
1. Amend state law to redefine grave disability. While the audit states that the definition of grave disability is adequate, this is an insufficient standard. LACDMH proposes an update of the definition to better protect individuals who are unable to safely live in the community. At a minimum, legislation should address the capacity of an individual to make informed decisions and include criteria regarding the need for significant supervision and assistance, risk for substantial bodily injury, worsening physical health as well as significant psychiatric deterioration and patterns of behavior that threaten the ability of others with whom they interact to live safely in community.
 2. Amend state law to authorize LPS conservators to manage physical health conditions, similar to the authority granted in Probate conservatorships.
 3. Add state law that would allow medical experts to share details with a court about a proposed conservatee that are observed by other medical personnel and staff as recorded in a medical record and not just those directly observed as limited by *People v. Sanchez*, 63 Cal 4th 665.
 4. Amend state law to allow for tele-testimony in LPS conservatorship hearings and trials to avoid unnecessary and often unsafe transport of clients. This issue is particularly timely given the coronavirus pandemic.
 5. Develop and enforce a standard application of danger to self, danger to others and grave disability criteria statewide. Legislature to provide resources appropriate for the county size and client population to implement these standards.
 6. Identify and dedicate sufficient funding to increase available treatment beds at all levels of care that provide an appropriate continuum of care that supports recovery. Some examples include: (a) Allocate funding to stabilize and prevent the loss of additional Adult Residential Facilities

(ARFs) and Residential Care Facilities for the Elderly (RCFEs) and to begin to rebuild its supply. (b) Work on a long-term strategy with the State Department of Health Services (DHCS) to make beds/placements for individuals with mental illness a Medicaid benefit or establish sustainable rates and program structure to support the long-term viability of ARFs and RCFEs. (c) Work with DHCS to advocate that Centers for Medicare and Medicaid Services update the Institution for Mental Diseases IMD exclusion in Medicaid.

7. Identify and dedicate a funding source to increase capacity and improve the surrogate decision-making and case management services by public guardians – a critical component in the LPS Act that has not received the necessary support to ensure compliance with provisions of the Act.
8. Identify and dedicate resources for conserved clients including but not limited to dedicated FSP programs, guaranteed housing and access to treatment beds (locked and/or unlocked) when indicated. Provide the resources necessary to ensure conservators both public and private (family members) have the training, transportation, and support to appropriately meet the recovery needs of the conservatees.
9. Address the increased demand for LPS conservatorships, with appropriate resources, for the forensic population incarcerated or confined to state hospital settings. This population often requires higher levels of care and more intensive services to address their complex mental health, substance use and physical health needs but the resources to meet these needs are insufficient or non-existent.

For a deeper understanding of these recommendations and concerns related to the audit findings, LACDMH provides the following perspective.

BACKGROUND

The LPS Act was groundbreaking when it was passed in 1967 with its intent (to name just a few) to end the inappropriate, and indefinite, involuntary commitment of persons with severe mental health disorders through a conservatorship program for persons considered to be gravely disabled. Even with critiques from all sides, the LPS Act has endured the test of time and robust attempts at modification. This Audit, which seeks to determine if updates, clarifications or improvements are needed to ensure that the definitions and equal application of California's mental health commitment procedures are adequate, has a number of limitations.

The LPS Act and specifically the use of involuntary treatment can be best contemplated as a way to set a balance between autonomy (the right to self-

determination) and paternalism (relegating that determination to others) in order to best serve the interests of an individual whose disability renders their capacity to make such determinations in question. While the civil liberties and decisional capacities of every individual should always be upheld as the basic cornerstone of rights and freedom, such civil liberties can come into conflict with the very safety and health of these same individuals and others with whom they interact directly and indirectly as the result of profound mental illness.

- ④ In the context of the LPS Act, the assumed definition of "danger to self" focuses on threats or actions that indicates the intent of a person to commit suicide or inflict serious bodily harm. However, a more comprehensive and accurate definition would also focus on a person's actions or omissions that place them in serious physical jeopardy. Although not clarified within the Act, this more accurate and comprehensive interpretation should be applied. It will improve access to care and provide prompt, incremental treatment to persons with mental disorders who are unwilling or incapable of accepting treatment. In fact, grave disability is danger to self in its chronic form. As explained in judicial opinions¹, it is the inability of an individual to live safely in community, because he/she is unable to provide for food, clothing, or shelter due to his/her mental illness. This inability, over time, results in physical deterioration, which is a chronic condition. Untreated, due to the lack of judgement and capacity related to a person's mental illness, this condition becomes acute and places a person in imminent harm. Danger to others has a chronic form as well which manifests when a person, due to profound mental illness, develops a re-occurring pattern of behavior that indiscriminately and randomly causes physical harm to others.

- ④ ***California's mental health system lacks not only the requisite procedural ability but also the dedicated resource capacity to properly compel treatment for individuals who are unable to live safely in the community and unable to engage meaningfully in treatment due to their mental health, physical health and/or substance use disorders.***

REFRAMING THE LPS ACT

LACDMH believes it is time to reframe and update the LPS Act in the context of providing opportunities for those with mental health disorders to live safely in the community and to access to the dedicated resources needed for compelling treatment to support recovery. Using this vantage point, it is suggested that

¹ In the context of grave disability, Judicial opinions actual refer to whether the non-dangerous person is capable of surviving safely in freedom." Conservatorship of Davis (1981) 124 Cal.App.3d 313; O'Connor v. Donaldson (1973) 422 U.S. 563. Additionally, the inability to live safely in community is an eligibility criteria for Assisted Outpatient Treatment.

involuntary treatment be used to ensure that every person in need is guaranteed access to the services to improve their quality of life. With these principles in mind, we are mandated as a humane society to provide both surrogate decisions and requisite resources to those whose chronic illness and inability to accept resources due to their illness prohibits their ability to live safely in community.

In order to realize such a commitment, modifications to the LPS Act and the definition of grave disability are necessary for individuals who are unable to live safely in the community. As such, ongoing efforts to modernize the LPS Act must remain a priority.

In this context, we respond directly to the following recommendations.

Chapter 1

The audit declares inappropriately that Los Angeles County has failed to provide adequate care for those individuals who received involuntary treatment. The audit concludes that individuals experiencing multiple short term 72-hour holds (5150's) are not linked to care based on data that LA County cannot access.

The audit also fails to consider that not all individuals who are assessed for a 5150 may qualify for further involuntary treatment and/or intensive specialty mental health services such as, Full Service Partnerships (FSP) or Assisted Outpatient Treatment (AOT) with its restrictive statutory eligibility criteria. Each individual should be assessed for the appropriate level of care. FSP is a high intensity, 24/7 program, reserved for the highest acuity clients. Referral to FSP services is determined by clinical history, clinical presentation, and functional assessment. Many people on brief holds are released within 24 hours or less and thus would not qualify for FSP or AOT level of services.

The issuance of a 5150 does not necessarily correlate to the need for specialty mental health services or services designed for higher acuity clients (FSP and AOT). There is a false assumption that all individuals placed on holds are "high-need" and require intensive mental health services. Although individuals should be assessed for the most appropriate level of care, individuals are at times placed on numerous 5150 holds for reasons other than a primary mental health disorder. While these individuals may need mental health treatment, outpatient services is most often the appropriate level of care. Data provided by the Mental Health Urgent Cares shows that in 85% of patients, treatment following a hold was for non-intensive services such as referrals/appointments to outpatient

⑦ mental health psychotherapy, outpatient psychiatric medication management, or referrals to outpatient substance use treatment. Additionally, the audit fails to acknowledge there are important built-in federal and state structural issues of capacity, resource availability, and medical necessity requirements which impact treatment options for individuals placed on 5150's.

⑤ LACDMH has worked tirelessly to transform the way in which mental health services are delivered within the County for those requiring involuntary treatment and/or conservatorship. We highlight some of these efforts as a counterpoint to the dramatic headings regarding the Los Angeles County mental health system, which are misleading and inaccurate.

- Development of the Public Guardian conservatee FSP program. This project serves to increase the number of conservatees enrolled in an FSP program and ensure continuity of care in the event the conservatorship is terminated.
- ⑧ • Outpatient Conservatorship program – contrary to the Audit report, LACDMH has instituted a pilot program allowing designated DMH outpatient clinical staff to refer for conservatorship without the need for an inpatient hospitalization. This program is expanding to include a pilot with the Homeless Outreach Mobile Engagement (HOME) team to make outpatient referrals to the Office of the Public Guardian.
- Implementation of the Therapeutic Transportation program, an Innovation funded project. This program, using specially outfitted vans staffed with mental health clinicians, mental health counsels, Registered Nurses and peer support specialists, offers a supportive and expedited response to transportation for individuals qualifying or at risk of an involuntary hold.
- Hospital in-reach from various programs:
 - Whole Person Care – a program focused on individuals with multiple hospitalizations, providing additional services to decrease repeat hospitalizations and increase the likelihood of successful transition back into the community.
 - Full Service Partnership – a 24/7 intensive outpatient program focused on working with the highest acuity, most vulnerable clients.
 - HOME – a specialty program working with chronically homeless individuals with serious mental illness.
- Service Area Navigators and hospital liaisons – local teams in each Service Area who work with psychiatric hospitals (both County and non-County) on identifying and linking with appropriate levels of care; also provide consultation on challenging cases, and in-services for hospital staff; these teams will also provide hospital in-reach and site visits.

- Prioritization of Hospital Discharge new intakes and follow up care – both appointments and walk-in services are available.
- The Men’s and Women’s Reintegration programs provide the same level of follow-up for individuals placed on a 5150 in a forensic setting through in-reach services followed by conditional release to the other programs.

Specific responses to Chapter 1 recommendations are as follows:

Recommendation No. 1: Require Justice to make the information that mental health facilities report to it about involuntary holds available to Health Care Services on an ongoing basis.

LA County agrees.

Recommendation No. 2: Require treatment facilities to report to Health Care Services all short-term holds that result from the grave disability criterion.

LA County agrees.

Recommendation No. 3: Direct Health Care Services to daily obtain the mental health facility information from Justice and make that information, as well as the information that facilities report directly to it, available to county mental health departments for county residents, and for a limited time for non-resident on an involuntary hold within the county.

LA County agrees.

Recommendations No. 4 (LA specific): No later than August 2021, adopt a systemic approach to identifying such individuals, obtaining available mental health history information about these individuals, and connecting these individuals to services that support their ongoing mental health.

LA County agrees in principal to the extent to which LACDMH can implement a systemic approach to identifying individuals placed on multiple short-term involuntary holds is dependent on resources being available and the implementation of the general recommendations by the state legislature. LACDMH will continue to deliver Medi-Cal services to individuals who qualify for specialty mental health services and voluntarily accept those services. Ultimately, the mental health network of care is comprised of various providers, including hospitals. A more appropriate recommendation, consistent with the audit scope, would be to treat and

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address this as a statewide network problem to address a potential gap in service.

Recommendation No. 5 (LA specific): By no later than August 2021, immediately implement a comprehensive solution such as using its own staff as expert witnesses to ensure conservatorships do not terminate because of the absence of testimony from doctors; and additionally should develop a revised approach to scheduling conservatorship hearings and trials so that it significantly reduces the rate at which doctors' failures to testify result in terminated conservatorships.

- ⑩ **LA County disagrees.** Developing a revised approach to scheduling conservatorship hearings and trials requires the cooperation of the Mental Health Court, Public Defender and other interested parties. Scheduling of hearings is the purview of the Mental Health Court and LACDMH has little independent influence in changing the scheduling process. But if logistical changes such as use of videoconferencing on a permanent basis, designating specific testimony times to eliminate hours long wait by testifying doctors, could be implemented it would increase the likelihood that treating doctors would testify. This would reduce the need for LACDMH to use its own doctors, particularly at a time when resources are limited and physicians are needed to meet ongoing treatment needs of clients.

Chapter 2

Chapter 2 focuses on changes to Assisted Outpatient Treatment (AOT) as a mechanism to promote long-term recovery particularly for individuals who struggle to maintain stability after their conservatorships are terminated. While LACDMH agrees with most of the recommendations in this section, we point out that changes regarding medication requirements and progressive measures to ensure medication compliance are not the same as involuntary medication, which is specific to a LPS conservatorship.

- ⑪ Medication non-adherence is multi-factorial but the audit appears to ascribe treatment non-adherence to individuals' choice or insight. Re-emergence of symptoms may be impacted and/or triggered by the reintroduction of substances, interpersonal stressors, and other social determinants of health and structural barriers (policies) as well as past negative experiences with treatment that contribute to medication non-adherence. For example, the more an individual is food insecure the less adherent they will be to medications as the majority of financial and other personal (time) resources will be focused on

meeting basic needs. This holds true for other needs like housing and personal safety. In addition, policies obstruct individuals' ability to adhere to medications. As one example under Medi-Cal provisions individuals can obtain only a 30-day supply of select medications at a time (including many psychotropic medications) whereas individuals with private insurance can obtain as large of a supply as is prescribed to them (e.g., 90 days). Lack of transportation to clinics or pharmacies, lack of safe places to store medications, concerns that medication side effects may place them at risk for violent victimization, cognitive deficits in psychotic disorders that limit some individuals' ability to reliably adhere to complex (or even simple) medication regimens—there are substantial barriers to medication adherence from the policy- to individual-levels. In addition, individuals served by public mental health systems are more under-resourced and more impacted by these social and structural determinants than are the general population. In sum, a mechanism for court-ordered medication will address some barriers to medication adherence but will leave the larger network of social determinants and structural barriers to adherence untouched.

Recommendation 1: Allow individuals who are exiting or have recently exited conservatorships to be eligible for those programs.

LA County agrees.

Recommendation 2: Provide express authority to include medication requirements in court-ordered assisted outpatient plans so long as the medication is self-administered.

LA County agrees in principal that the law should be clarified to include court ordered medication but points out that court ordered medication is not involuntary medication, which should remain an order within a conservatorship.

Recommendation 3: Include progressive measures to encourage compliance with assisted outpatient treatment plans such as additional visits with medical professionals and more frequent court appearances.

LA County agrees in principal with the use of increased visits by medical professionals and increased court appearances to improve medication compliance but court appearances would require cooperation from the Mental Health Court, Public Defender and County Counsel. Furthermore, progressive interventions including taking clients to facilities for treatment to promote adherence could have the opposite effect and borders on the appearance of force.

Recommendation 4: Amend state law to require counties to adopt assisted outpatient programs and allow counties to opt-out by seeking a time-limited waiver from DHCS.

LA County has no position on this recommendation and acknowledges that there is pending AOT legislation.

Chapter 3

⑫ This chapter lacks adequate understanding of the funding structure for the county public Medi-Cal behavioral health system as a whole. LACDMH disagrees with all of the stated recommendations. Mental health funding is not flexible- Medi-Cal, Realignment, and even MHSA have statutory requirements that must be followed in the delivery of these services. For context, Medi-Cal covers 13 million Californians (1 in 3) and is a \$105.2 billion program. County behavioral health accounts for \$6 billion of the \$105.2 billion budget. It is important to consider these important factors in their proper perspective in order to fully understand the health care delivery system. For years, advocates have been saying that behavioral health is underfunded.

⑫ The report fails to articulate numerous issues facing counties including these key items: (1) Fundamentally, the report demonstrated a lack of understanding of how Medicaid and the current 1915(b) waiver drives the local mental health system, with non-federal share funding streams such as MHSA and realignment supporting the Medi-Cal funding structure; (2) The importance of county-specific, stakeholder-informed process; (3) MHSA funds are distributed as three-year funding cycles and creates fiscal cliffs. In addition, MHSA funding categories and MHSA year to year volatility lead to undesirable one-time (as opposed to ongoing) programmatic funding investments; (4) Ongoing current statewide reporting exists and has demonstrated the positive impact of mental health services across the State. (5) The audit conclusions must be re-considered within the context of revenue loss at the local and State levels due to COVID-19.

The need for additional services is countercyclical to the economy. More Californians will qualify for Medi-Cal Behavioral Health due to job loss. The COVID-19 pandemic has also caused an increase in demand for services, especially for in mental health. All projections show that all mental health funding sources that counties receive will decrease significantly over the upcoming years as the U.S. and California face economic recession. New Medi-Cal beneficiaries do not come with new funding and counties will have to use declining realignment and MHSA to pay for the required non-federal share of Medi-Cal.

The Audit implies that unspent funds are those that counties have not accounted for or used in any way and are sitting on MHSA funds without serving those with mental illness. In fact, “unspent funds” are unspent because they are either unavailable to spend (i.e. Prudent Reserve which is statutorily defined), locked into spending for 5 year Innovation projects or encumbered for specific MHSA programs in the LACDMH budget that are ongoing, modified or brand new. These programs and their allocated funds/expenditures are vetted through an arduous stakeholder process with myriad client, family, neighborhood and community partners. These “unspent funds” are all accounted for and encumbered for dedicated programs through contracts and other formal mechanisms in subsequent years. See the attached diagram.

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It is also important to reiterate that MHSA revenue is volatile due to being based on income tax and allocations determined by DHCS (meaning it is prudent to hold some balances so that the county could maintain services during low-revenue years). This economic reality is very relevant during this COVID-19 pandemic. In addition, it should be noted that LACDMH has not reverted any amount of MHSA funds to the State.

⑭

Recommendation 1: Assign primary responsibility to the Oversight Commission (OAC) for comprehensive tracking of spending on mental health programs and services from major fund sources and of program and service level and statewide outcome data.

LA County disagrees. LA County finds this unnecessary and counter-productive. The authors of the MHSA had the foresight and were careful to create a separation of duties such that the State Department (DMH and now DHCS) had the contractual relationships with the counties/Mental Health Plans, which includes compliance reviews separate from the oversight and accountability function fulfilled by appointed Commissioners. LA County would not endorse changes that would involve the OAC taking on functions beyond what was intended in the MHSA Act.

⑮

Counties are actively engaged in statewide reporting on MHSA programs. A leading example is the joint County Behavioral Health Directors Association- California Institute for Behavioral Health Solutions (CBHDA-CIBHS) statewide reporting initiative acknowledged by the Little Hoover Commission, called Measurements, Outcomes and Quality Assessments (MOQA) initiatives that produced reports in 2015 and 2016 on statewide FSP outcomes. Currently MOQA is focusing on MHSA Prevention

program outcomes including those related to suicide prevention, stigma, and discrimination reduction.

In addition to MHSA, the Medi-Cal program established a host of reporting requirements through 42 CFR, Part 438, subpart E, including Consumer Satisfaction Surveys and Quality Improvement activities that include annual data-driven Performance Improvement Projects for clinical as well as non-clinical activities, annual quality improvement work plans that involve the establishment and evaluation of Mental Health Plan goals, participation in an annual External Quality Review and the reporting of client demographics.

The State Department of Health Care Services (DHCS) oversees the provision of Medi-Cal Specialty Mental Health Services (SMHS) to beneficiaries across the State but delegates the strategic planning of service delivery within each county to the county's Mental Health Plan (MHP) Director. The reason for this is clear – it is the county MHP Director that can best tailor the overall service delivery priorities to the unique needs of the county. The addition of an oversight commission adds an unnecessary layer of bureaucracy to this process. Under the SMHS Contract with DHCS, DHCS requires county MHPs to assess their own capacity and need for services by “monitoring the number, type, and geographic distribution of mental health services within the delivery system.” In addition, under the Medicaid Managed Care and CHIP Managed Care Final Rule, 42 CFR 438.340, each state Medicaid agency is required to implement a written quality strategy to assess and improve the quality of health care and services furnished by all Medicaid managed care entities. The Comprehensive Quality Strategy outlines the MHP's process for developing and maintaining a broader quality strategy to assess the quality of care that all of the County's beneficiaries receive, regardless of delivery system, and defines measurable goals and tracks improvement while adhering to the regulatory managed care requirements of 42 Code of Federal Regulations (CFR) 438.340.

If this recommendation is acted on, LA County suggests an alternative agency for this responsibility, DHCS, because of their familiarity of Medi-Cal, Realignment, and MHSA funding. They have a performance contract with each Mental Health Plan and oversee MHSA compliance.

Recommendation 2: Require the Oversight Commission to develop categories of mental health programs and services that are tailored to inform assessments of spending patterns. The legislature should require counties to report their

expenses in each of these categories as well as their unspent funding from all major funding sources.

Recommendation 3: Require counties to report to the Oversight Commission program and service level outcomes that enable stakeholders to determine whether counties use of funds benefits individuals living with mental illnesses.

LA County disagrees with Recommendation 2 and 3. With respect to the delivery of individual SMHS, services are not provided to Medi-Cal beneficiaries based on categorical spending patterns. The delivery of services is based on the specific needs of each client as determined by an individualized assessment and collaborative treatment planning process. In the vast majority of cases, services are voluntary, and it is the client's choice as to which services they choose to accept as recommended by the treatment provider. This individualized client-driven approach is reflected in the guiding principle of Medi-Cal SMHS, the Rehabilitation Option under the State 1915b waiver: *"The provision of services and support should ... be directed and determined by the individual's needs and desires, whenever possible. The system must focus on the individualized needs, strengths, and choices and demonstrate individual involvement in service planning and implementation."*

⑩

And within the County's contract with the State DHCS: *"Services shall be provided, in accordance with the State Plan, to beneficiaries, who meet medical necessity criteria, based on the beneficiary's need for services established by an assessment and documented in the client plan. Services shall be provided in an amount, duration, and scope as specified in the individualized Client Plan for each beneficiary."*

In addition, the MHSR Revenue and Expenditure Report (RER) adequately classifies programs according to MHSR component. Counties are required to complete and submit annual RERs and 3-Year Plans with Annual Updates that serve as fiscal and programmatic documentation of county programs, utilization and associated funding. Each year's RER documents Medi-Cal, 1991 Realignment, Behavioral Health Subaccount and other funding associated with each CSS work plan, each component of PEI and all other MHSR components.

MHSR currently stipulates the outcome data collection and reporting requirements, which already informs stakeholder recommendations on programs and services. Required outcome data are transmitted directly to DHCS for FSP programs and incorporated into county Annual Updates

and 3-Year Plans. In addition, counties are required to submit annual reports to the OAC on PEI, including outcomes stipulated in the regulations, and Innovation projects.

Recommendation 4: Require the Oversight Commission to work with counties and other state and local agencies to use the information it collects to improve mental health in California.

LA County does not support a role beyond the role the OAC currently plays in bringing counties together who are working on similar projects for cross-county learning and dissemination.

Recommendation 5: Amend state law to identify those who have left LPS Act holds and who experience serious mental illness as a population that MHSA funds must target.

- ⑰ **LA County disagrees.** This recommendation is unnecessary because MHSA funds are currently used for those individuals with serious mental illness who are released from involuntary holds.

Recommendation 6: Establish a goal in the MHSA of connecting all such individuals to the community based program and services they would benefit from and require counties to fund efforts to link these individuals to those programs and services and that goal of these programs and services is to reduce the number of repeated involuntary holds or conservatorships that occur.

- ⑱ **LA County disagrees.** This recommendation is unnecessary because MHSA funds are currently used to connect individuals to community-based efforts. The audit fails to recognize the need for LPS reform is not to target those that voluntarily accept treatment (core component of MHSA) but rather those individuals who do not accept care.

Recommendation 7: Specify that counties can use any portion of their MHSA funds for this purpose as long as they comply with other statutory and regulatory requirements and amend state law to explicitly require counties to including information about this balance of unspent MHSA funds in their MHSA annual revenue and expenditure reports.

- ⑰ **LA County disagrees.** It is unnecessary to specify that counties can use any portion of MHSA funds to connect individuals to community-based efforts because counties currently have the ability to use funds for this

purpose as long as the stakeholder process approves the expenditure as part of the 3-year plan. Amending state law to specify the format of annual revenue and expenditure reports is too restrictive and prevents state and local agencies from adjusting reports as necessary to address the changing landscape of public mental health financing.

LACDMH also comments on the lack of recommendations in Chapter 3 related to the Office of the Public Guardian.

The audit fails to address funding related to the Office of the Public Guardian and the conservatees they serve. A comprehensive review of the LPS Act and funding of the services cannot be done without looking at a core component of the Act – the county conservatorship investigator and court appointed conservator – Public Guardian. While increased reporting related to Medi-Cal and Realignment may indicate county support for the public guardian program or the placements funded for conservatees this falls short of addressing the fact that public guardian programs do not have a dedicated funding source. The extent to which a public guardian program exists or the extent to which the program can meet the needs of its conservatees is subject to the availability of realignment funding and county general funds. The issue is directly related to the scope of the audit, specifically to determine how counties fund their implementations of the LPS Act and whether access to funding is a barrier to the implementation and the audit failed to address this issue as part of their audit scope.

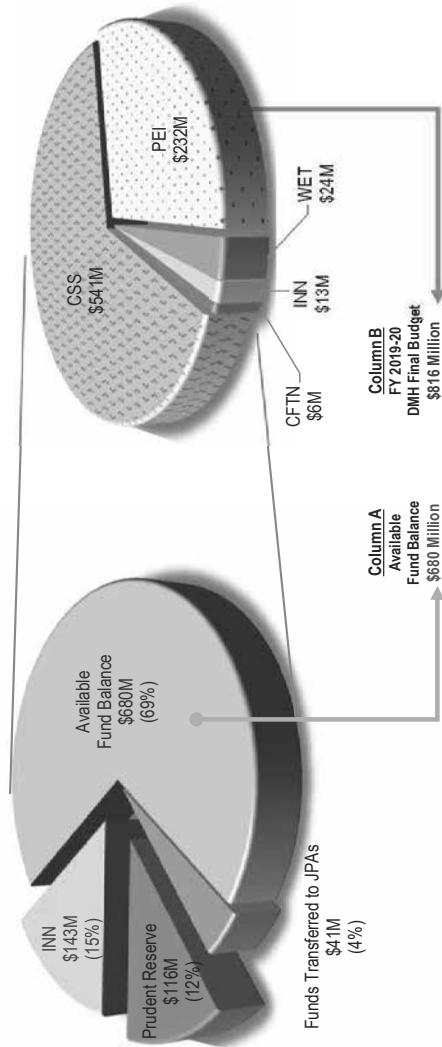
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Conclusion

The Los Angeles County Department of Mental Health looks forward to continue working with the Auditor's Office and with the State Legislature to enact needed changes to the LPS Act, among other issues, that would ultimately provide better services to those living with mental health disorders.

###

MHSA
Total Fund Balance
\$980 Million*
As of June 30, 2019



▪ The total cumulative unspent at the start of FY 2019-20 is \$939M. The FY starts July 1, 2019.

▪ Of this amount:

- 1) **\$116M is restricted to the Prudent Reserve as set by statute**, and
- 2) **\$143M is earmarked for approved INN projects**. Neither of these can be accessed or altered.
- This leaves a balance of **\$680M in available fund balance** (column A) that is encumbered towards **\$816M in budgeted existing MHSA programs** (column B) which exceed the available fund balance.

*Note:

The audit report shows the total unspent balance at \$980M. In March 2020, DMH provided information to the State Auditor based on a cash balance of \$939M.

The variance of \$41M is primarily attributable to the differences in reporting requirements between the County and the State. The \$939M is the cash balance after accounting for transfers made to Joint Power Authority (JPA), whereas the \$980M does not recognize these transfers so long as the funds have not been fully expended by the JPAs.

Column A
Available
Fund Balance
\$680 Million

Column A Available Fund Balance \$680 Million	Column B FY 2019-20 Final Budget \$816 Million
CSS	\$541M
PEI	\$232M
WET	\$24M
CFTN	\$6M

Available FB \$680M

INN	\$143M
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BUDGETED MHSA
PROGRAMS \$816M

PR	\$116M
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LOS ANGELES COUNTY
FUND BALANCE (CASH) \$939M

PR	\$41M
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See note

AUDIT REPORT
UNSPENT BALANCE \$980M

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM LOS ANGELES COUNTY

To provide clarity and perspective, we are commenting on Los Angeles's response to our audit. The numbers below correspond to the numbers we have placed in the margin of Los Angeles's response.

Los Angeles incorrectly asserts that we failed to conduct a deep analysis of the LPS Act. Our report includes a thorough description of our analysis of the intent of the LPS Act and counties' implementation of the act, which was based primarily on the case files we reviewed across all three counties. We performed work in the areas the Legislature asked us to look at. As Table A on page 67 shows, the Legislature specifically asked us to review the services (including county-provided services) available to individuals receiving treatment through the LPS Act (Objective 7), the implementation of the LPS Act (Objective 4)—which includes the way in which a county pursues conservatorships in court—and the availability of funding to provide care under the LPS Act (Objective 6). Finally, Los Angeles has MHSA funding that it has not spent. Therefore, Los Angeles's assertion that some MHSA funds are unspent is a myth is incorrect.

①

During our review, we considered the county's ideas for legislative change. The recommendations we make in our report are based on the evidence we found in the course of our review. The recommendations Los Angeles suggested are either not supported by our evidence or are outside the scope of our review.

②

As we explain beginning on page 17, we found that the current definition of grave disability enabled designated professionals authority to treat individuals in need of services through the LPS Act. As shown in Figure 5, on page 19, we found that designated professionals in the counties we reviewed applied the definition in a consistent manner. Further, we note on page 18 that we observed that designated professionals in the counties we reviewed used definitions of grave disability that were not overly restrictive. As we conclude on page 21, expanding or revising the criteria for LPS Act holds could widen the use of involuntary holds and pose significant concerns about infringement on individual rights. Therefore, we do not recommend that the Legislature amend the grave disability criterion of the LPS Act.

③

- ④ Los Angeles presents a case that the LPS Act's involuntary hold criteria are not well defined because there are broader ways to consider—for example—when someone is a danger to themselves other than the fact that someone is suicidal. However, we did not observe that counties only adhered to a rigid definition of danger to self. Instead, as we note on pages 19 and 20, counties applied that criterion when individuals, because of their mental illness, engaged in behaviors that were apparently dangerous, such as the consumption of dangerous foreign objects. We noted similar flexibility in how the counties applied the other involuntary hold criteria as well. Because of our observations across three counties, we do not agree with Los Angeles's assertion that California's mental health system lacks the procedural ability to apply involuntary holds when necessary.
- ⑤ Our conclusion that the county failed to provide adequate care to individuals leaving involuntary holds is based on the results of our review. Specifically, as we describe on page 32, we found that only 9 percent of individuals who had experienced five or more short-term holds from fiscal year 2015–16 through 2017–18 were enrolled in intensive outpatient treatment services in fiscal year 2018–19. Further, we describe that about one-third of individuals from our case file review with a high number of short-term holds in their lifetime were not enrolled in these services at any point from fiscal year 2016–17 through 2018–19. Finally, we report that six of the nine individuals we reviewed who had been held multiple times in their lifetime were not linked to services in the two weeks following the end of their short-term hold. We acknowledge on page 35 of our report that limited access to quality data contributed to this failure, and on page 37 we recommend a solution to the data access problem. However, neither data issues nor other potential barriers that the county indicates absolve it of the responsibility to provide care to individuals who have experienced multiple mental health crises.
- ⑥ As we explain on page 32 of our report, we focused our analysis on individuals who experienced multiple involuntary holds over a short period of time. We question the county's suggestion that such individuals did not need intensive services, such as full-service partnerships or assisted outpatient treatment. In fact, in its own response, the county indicates that such programs have been part of its attempt to transform the way in which mental health services are delivered to those requiring involuntary treatment.
- ⑦ Los Angeles criticizes our audit for a failure to acknowledge factors of capacity, resource availability, and medical necessity requirements. However, we addressed capacity issues beginning on page 21 of our report, and Los Angeles was not clear what it meant by resource availability and medical necessity. Without additional detail it is not possible to more directly address Los Angeles's concerns.

On page 50 of our report we discuss community conservatorships, which were unique to San Francisco. These programs allowed the public guardian to oversee court-ordered medication for individuals whom the public guardian placed in community housing, instead of treatment facilities during the period of conservatorship. The program that Los Angeles cites in its response allows referrals for conservatorship to come from community settings rather than hospital settings. This does not mean that treatment during conservatorship, if one is established, would occur in the community. As we state on page 50, the deputy director public guardian for Los Angeles expressed concerns that administering medication—which our review found was often a critical component of mental health treatment—would not be feasible in a community setting.

⑧

Los Angeles's response indicates that it will only adopt our recommendation to the extent that resources become available and the Legislature acts on our associated recommendations. Given the importance of linking individuals to mental health services, we believe that Los Angeles should take steps now to improve how it identifies individuals who need services and links those individuals to services. We look forward to reviewing the county's 60-day response to our audit that should indicate the steps it is taking to implement this recommendation.

⑨

We believe the county should coordinate with the court and other parties to revise the approach to scheduling conservatorship hearings—steps the county would likely need to take to achieve the other logistical changes it suggests in its response. Our analysis of this issue, described on page 30, determined that a key reason why conservatorships in Los Angeles terminated was a doctor's failure to testify. Further, on that same page we describe the county's own determination that 20 percent of conservatorships ended because doctors did not testify. In light of these findings, our suggestion to use county doctors to provide critical medical testimony is consistent with meeting ongoing treatment needs for individuals who require conservatorships.

⑩

We acknowledge that many factors may influence whether individuals take prescribed medication. Our report focuses on an individual's level of insight into their mental illness—the degree to which the individual believes that they have a mental health related illness—because the evidence we reviewed indicated it was a key factor influencing whether the individuals whose cases we reviewed continued to take their medication.

⑪

- ⑫ We stand by our description and analysis of issues concerning funding for mental health services in California and the recommendations we make to increase the transparency of spending on mental health services and the accountability for outcomes related to those services. Los Angeles expresses concern that our report does not explicitly describe certain statutory requirements and county-level funding issues. However, we do not believe the issues that Los Angeles raises in its response are barriers to the implementation of our recommendations.
- ⑬ Los Angeles's concerns about our characterization of unspent funds are unfounded. We clearly indicate on page 55 that the counties we reviewed explained that some of their MHPA unspent funding had already been allocated to planned uses in subsequent years. Also, we removed each county's prudent reserve from our calculation of its unspent fund balance in Table 2 on page 56.
- ⑭ The county did not provide this graphic to us before submitting its response to our report. We did not review the data that underlies the graphic that Los Angeles provided and therefore have no comment on the accuracy of the graphic and the information it provides about MHPA funds. However, we note that the county's presentation does not include funding that would have been left as unspent at the close of fiscal year 2019–20.
- ⑮ Los Angeles's response primarily takes issue with our recommendation that the Oversight Commission be tasked with comprehensive tracking for mental health care spending and outcomes. As we state on page 62, we recommend the Legislature assign this responsibility to the Oversight Commission because of the overlap between existing reporting responsibilities and our proposed framework, as well as the work already performed by the Oversight Commission.
- ⑯ In objection to our recommendations, Los Angeles lists observations about current mental health service delivery and reporting requirements. It appears that Los Angeles misunderstands the intent of our recommendation. Our recommendation would have counties report about their spending and mental health service delivery across common categories regardless of funding source. Although we acknowledge on page 62 that there may be some overlap between our proposal and existing requirements, the existence of the current service delivery and reporting requirements does not invalidate our proposal for a comprehensive framework for understanding aggregated spending and service outcomes.

Los Angeles's argument that these recommendations are unnecessary simply because counties are already allowed to spend their funds in the manner we recommend is insufficient. Put simply, there is a meaningful difference between being allowed to spend funding in a specific manner and being directed to do so. The results of our review demonstrate the need for requirements in these areas.

⑰

We disagree with Los Angeles and stand by our recommendation. Our review shows that individuals who have been treated under the LPS Act are often not successfully connected to mental health care following their involuntary treatment. On page 32 we detail how only 9 percent of individuals with a high number of involuntary holds were enrolled in intensive outpatient treatment. We also explain on that same page that some individuals who had experienced multiple holds in their lifetime were not offered any mental health services in the two weeks that followed the involuntary hold we reviewed. Los Angeles argues that simply because counties can spend their MHSA funds to link individuals to mental health care that they should not face a requirement to do so.

⑱

We reviewed county documents related to public guardian funding as part of our work to identify funding for the implementation of the LPS Act and potential barriers to implementation. In our discussion of Figure 4 on page 15 we describe that counties draw on a variety of resources—including locally generated funds—to fund mental health services. Our review did not lead us to conclude that a lack of funding for public guardians was a barrier to implementing the LPS Act. Los Angeles's response observes that the public guardian's office is funded through realignment and county general fund monies instead of through a dedicated funding source. Our recommendations for improved reporting about the use of funds for mental health treatment should help indicate underfunded areas going forward, as the county acknowledges in its response.

⑲

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July 2020

City and County of San Francisco
London N. Breed, *Mayor*



Department of Public Health
Grant Colfax, MD, *Director of Health*

Department of Disability and Ageing Services
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California State Auditor*
621 Capitol Mall Suite 1200, Sacramento, CA 95814

To Whom It May Concern:

San Francisco County thanks the State Auditors for their detailed review of the LPS Act, as well as their collaboration and commitment to understand the complexities of serving individuals who have behavioral health needs, particularly those who have acute service needs. We appreciate the depth of the report and the ability to respond to the recommendations and would like to take this opportunity to share our experiences, as well as provide some additional information for consideration.

As is indicated in the report, San Francisco has always strived to be innovative in our response to serve our most vulnerable residents by providing services that are client-centered, compassionate, and intended to promote wellness and recovery. While it is both our legal and ethical duty to ensure that individuals are served in the least restrictive setting, court ordered treatment options are an important part of our continuum of care. We are pleased that the State confirmed that we are appropriately administering and overseeing mental health conservatorships, as outlined in the LPS Act. San Francisco's approach to both Assisted Outpatient Treatment and flexibility in serving individuals on an LPS Conservatorship in the community is the result of a client centered approach, collaboration across city departments and community based organizations, and innovative and adaptive ways in which we have been able to model and serve individuals in need.

The report also highlighted San Francisco's innovative Community Independence Participation Program (CIPP) and our Post-Acute Community Conservatorship (PACC) in the report, although they were not referenced by name. Both CIPP and PACC are innovative services models that are operated under the LPS Act that promote the client's engagement in their own recovery while supporting a client's placement in a non-restrictive, community based setting. These models are operated under existing LPS statute, and therefore would not be considered separate conservatorship programs or an alternative to AOT. Despite these programs, San Francisco, like many counties across California, is struggling with the severity of needs of our residents who have mental illness, particularly when this is impacted by the effects of psychoactive substances, complex trauma, homelessness, racial oppression, and medical pandemics. While COVID-19 response has a significant impact across California and the nation, we would be remiss not to highlight the impact of the virus on our most vulnerable residents, the focus of staff on mitigating the spread of the virus on our communities at this time, as well as the potentially detrimental impacts on our funding to implement the recommendations outlined in the report.

We would also like to take this opportunity to provide feedback on recommendations and conclusions in the report:

Report: Expanding the LPS Act’s criteria for involuntary holds or revising the criteria to include standards that are overly broad—such as the ability to live safely in one’s community—could potentially widen the use of involuntary holds, which would pose significant concerns about infringement on individual rights. We found no evidence to justify such a change.

Response: San Francisco agrees that the “LPS Act’s criteria appropriately enabled the designated professionals to place people who needed involuntary treatment on LPS Act holds or conservatorships.” San Francisco partners with our legal and patient’s rights partners to responsibly implement and utilize existing holds. Despite this, we still believe *there is room for improvement in the LPS Act* in order to ensure that those with significant behavioral health needs are able to receive acute care, and not just crisis services, when in need. While a very small proportion of individuals with serious mental illness have episodes of violence, individuals with mental illness are disproportionately victims of violence in our communities. We encourage every effort to protect these individuals and support patient rights protections to ensure that involuntary care is a last resort to support the recovery and wellness of an individual; however, as experts in behavioral health it is our professional opinion that these resources are needed in serious cases.

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With the above in mind, we recommend that the legislature consider adding language to better define grave disability so that there is consistency across jurisdictions and that the subjectivity that may exist for providers and/or the Court is mitigated. San Francisco has recently implemented Housing Conservatorship (updated as Senate Bill 40 in October 2019), which attempts to address some of the gaps in the LPS Act that behavioral health professionals struggle with. Despite the ability to pilot new tools in our community, we strongly recommend there be considerations related to the LPS Act to account for advancements in our understanding of serious behavioral health needs and impact of psychoactive substances outside of chronic alcohol use.

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This report provides an important opportunity to open a discussion and modernize the LPS Act to ensure that interventions are data driven and individuals receive comparable interventions across counties to further protect the rights of those that are most vulnerable and in crisis. We recognize the traumatic history of involuntary treatment, and the negative experiences that individuals may currently face when interacting with the mental health system, so these changes should not be made without the input of medical professionals and those with lived experience to ensure that we continue to approach this work from a compassionate, yet needed, stance.

Report: San Francisco Recommendation- By August 2021, San Francisco should conduct an assessment to determine the number and type of treatment beds that it needs to provide adequate care to individuals receiving involuntary treatment. Once the assessment is complete, the county should adopt plans to develop the needed capacity.

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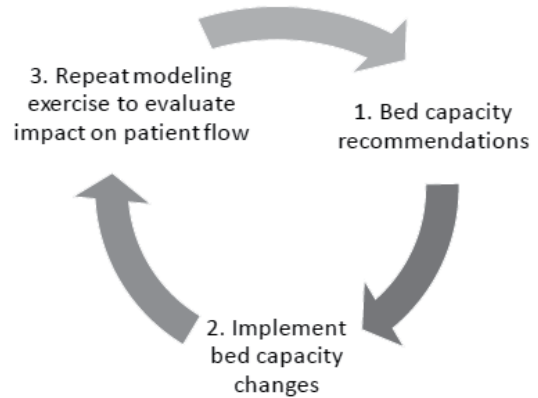
Response: In June of 2020, the San Francisco Department of Public Health published a “Behavioral Health Bed Optimization Project Analysis and Recommendations for Improving Patient Flow” report. This report utilized a robust statistical analysis of fiscal year 18/19 data to do a bed simulation model and identify recommended investments across our behavioral health system of care to maximize client flow (See Table below). This analysis represents a first step to meet the current need for beds based on wait times and additional investments may be needed to address the overall demand for beds. We are working at a county level to implement these recommendations for

bed investments and look forward to conducting this analysis on an ongoing basis to identify needed investments.

Behavioral Health Investment Recommendations

Bed Category	Recommended Bed Increase	Annual Cost of Recommended Bed Increase*
Locked Subacute Treatment	31	\$5,493,433
Psychiatric Skilled Nursing Facility	13	\$1,385,540
Residential Care Facilities aka Board and Care	31	\$973,090
Residential Care Facilities for the Elderly	22	\$855,195
Mental Health Residential Treatment (12-month)	20	\$1,942,530
Total	117	\$10,649,788

**cost calculated using median cost per bed per day*



... and for each new bed investment, create one long-term housing placement.

In order to effectively provide services to individuals in need and to maximize investments in additional treatment beds and expanded treatment capacity, associated funding must also be flexible. The San Francisco County General Fund provides a significant portion of Behavioral Health Services funding (31 percent of total budget). While San Francisco is committed to investing in our community members, we support State efforts to reduce barriers to bill Medi-Cal and other revenue sources in order to ensure that billing is client centered and outcome driven, rather than being mired by documentation requirements and billing codes. Further, these investments must support low threshold services in order to successfully meet and engage individuals where they are at, and, when appropriate, support individuals to link to more traditional models of care.

The report notes that, “California has closed several of its state hospital facilities, which generally provide intensive treatment in locked settings for those with serious mental illnesses.” While we fully support individuals receiving treatment in their county of origin, there is a need for placements that can support individuals with serious neurobehavioral conditions and those at heightened risk of violence. At this time counties across California are attempting to access a small number of State Hospital beds, which can lead to exorbitant wait times, in some cases over a year, for individuals to receive the appropriate level of care. We believe more beds are needed across California and that the state should play a role in providing funding for those beds.

Report: San Francisco Recommendation- By August 2021, San Francisco should adopt a systemic approach to identifying individuals placed on multiple involuntary holds in its county-designated facilities, obtaining information about those individuals, and connecting them to services that support their ongoing mental health.

Response: San Francisco agrees with this recommendation and continues to support individuals with behavioral health needs by providing continuity and connection to care. While it is important to note that engagement in services is voluntary, we aim to provide care coordination and proactive wrap around services to individuals who are deteriorating in our communities. The Department of Public Health provides behavioral health services to approximately 30,000 individuals every year. We are currently engaging in a quality improvement process to analyze and enhance our response and length of time for a follow up appointment at our outpatient clinics after a crisis. Further, San Francisco recently passed legislation that would create a program called Mental Health SF, which includes the development of an Office of Care Coordination. This office would employ a “whatever and wherever it takes” approach to engage individuals in services and support navigation into ongoing care. This office will be positioned to implement the report’s recommendation.

San Francisco has also had great success in a Linkage Model of care for Transitional Age Youth to support individuals, who frequently have prodromal symptoms of serious mental illness, to successfully transition from the Children, Youth, and Families System of Care to the Adult/Older Adult System of Care. As clients in need transition to higher levels of care, it also becomes increasingly important to ensure client flow and successfully transition other clients to lower levels of care, which both creates capacity in the higher levels and ensures that clients are treated at the most appropriate level of care. In order to achieve this, the Department of Public Health has been working closely with our intensive case management providers to complete utilization management reviews and are using MHSA Innovation funds to provide peer support to individuals who are showing signs of recovery and are able to access less intensive care in the community. Through this program, clients are guided through all the various steps from preparation to successful placement and/or discharge.

Further, in our clinics, which provide integrated medical homes and mental health services, we have partnered to have Health Home Care Coordination, which allows providers to be notified if an individual they are supporting is receiving emergent services. Additionally, we have used grant funds to enhance services at Psychiatric Emergency Services at Zuckerberg San Francisco General Hospital, our primary designated LPS facility for 5150 WIC holds, to provide support and engagement to individuals who have repeated crisis contacts. Finally, our Shared Priority Project through Whole Person Care has provided us with a great deal of success and recommendations of investments to support individuals with complex medical and psychiatric needs who are experiencing homelessness. This includes the need to invest in care coordination, as well as address systemic challenges to reduce barriers to access care.

Additionally, as discussed above, we believe that the legislature should consider all alternatives to serve vulnerable individuals who cycle in and out of crisis and are deteriorating in our community. System improvements and investments to a variety of voluntary treatment options are needed; however, it remains important for a small subset of the population who are unable to participate in

voluntary services to have other alternatives.

Report: Legislative Recommendation- Adjust reporting requirements for LPS Act holds to ensure that counties can access existing state-managed data about the specific individuals placed on holds.

Response: We *strongly* support the recommendation that counties have access to information regarding LPS holds for their residents so that we can effectively intervene and proactively support individuals who are at risk of more restrictive holds/placement. We would also like to note that many individuals that experienced psychiatric crises during the evaluation period have private insurance. As San Francisco Department of Public Health has a key role in providing behavioral health services to low income, uninsured, and vulnerable residents, we ask that recommendations also consider the role of private insurance entities to maintain responsibility for the provision of equitable services to their beneficiaries.

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We also question whether the proposed solution (that DOJ information about patients on a 5150 should be made available to the State, which would make it available to the County) is viable, as it would likely take time for the data to filter through so many agencies. Care coordination for patients who are on involuntary holds requires "live" data as the clinical team needs to act quickly for appropriate linkage. We suggest that other solutions, such as those envisioned in Health Insurance Exchanges (HIE) be investigated.

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Report: Legislative Recommendation- Require counties to adopt assisted outpatient treatment programs.

Response: We *strongly* support the adoption and implementation of Assisted Outpatient Treatment across California as a less restrictive option to support individuals in their journey to recovery and wellness. Given our innovative approach to implementation, as well as our overwhelming success with this program, we would be happy to offer our expertise as a subject matter expert should the legislature consider making changes to this program. We also encourage the consideration of including funding to implement these programs in a comprehensive way.

However, we respectfully disagree with the conclusion that the engagement period can slow access to care (Page 44). Rather, in San Francisco, the engagement period is a time where care is proactively offered by a team of clinicians and peers to support individuals in accepting ongoing voluntary services. San Francisco has seen an approximately 80% success rate in individuals accepting voluntary services through Assisted Outpatient Treatment, largely in response to this intensive engagement period. While at times it can be difficult to locate individuals over a period of time, we believe that shortening or reducing the engagement period would not provide any substantial positive impact to enroll individuals. That being said, Legislative Recommendation 1 would further allow the Assisted Outpatient Treatment team to coordinate care and identify emergent contacts at non-public hospitals, which would enhance our ability to locate and engage individuals.

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Report: Legislative Recommendation-Assign the Oversight Commission primary responsibility for developing, implementing, and overseeing a comprehensive framework for reporting mental health spending across all major fund sources, as well as program-specific and statewide mental health outcomes.

Response: We *strongly* support the recommendation to increase transparency and community engagement around the LPS Act, outcomes, and spending. We encourage this recommendation to also include resources to develop infrastructure to ensure responsiveness and coordination across counties at the Oversight Commission level. Further, the importance of strong data collection across these efforts is needed at the county level, as well as clear and consistent metrics across counties. We recommend that there be additional funding to support data analysts for the counties.

Report: Legislative Recommendation- Direct counties to spend MHSA funds for the purpose of connecting individuals leaving LPS Act holds or conservatorships to community-based services.

Response: We *support* the opportunity to leverage MHSA funds to provide care to individuals who are exiting 5150 WIC hold or conservatorships. The core values of MHSA include a strength-based approach and are prevention driven. San Francisco's ability to utilize MHSA dollars flexibly to meet the unique needs of our community remain important.

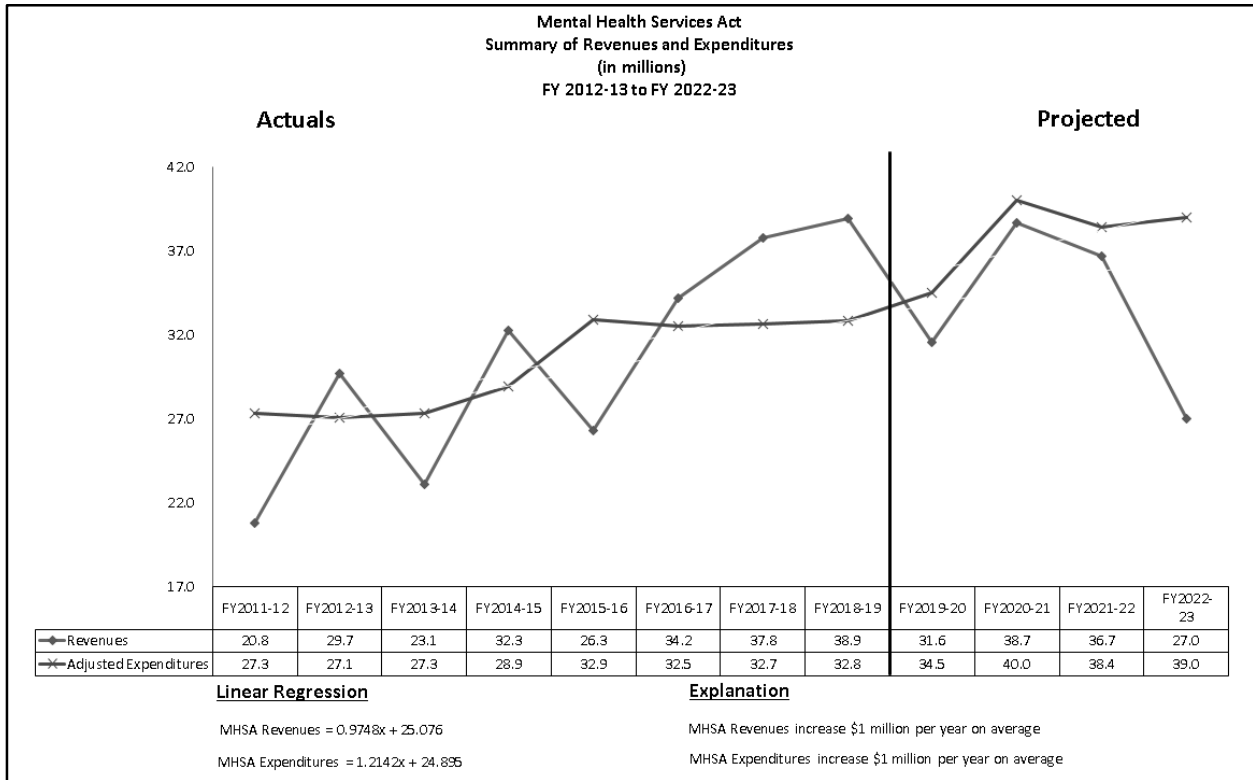
To assist stakeholders and policymakers when assessing the ability of using MHSA funds to support programs, we request that the report describe the restriction on using MHSA funds to supplant existing state or county funds used to provide mental health services.

Any proposal to use MHSA funds for mental health activities that are funded through other state resources (example - general fund or trial court trust fund) is contingent on those resources maintaining the same level of funding for those services. Per WIC 5891(a), MHSA can be used for expansions, but it cannot be used to replace another funding source.

The report also states that San Francisco has \$27.9 million of unspent MHSA funds. San Francisco is committed to maintaining a consistent level of MHSA services through both periods of economic prosperity and economic downturn. To fulfill this objective, we expand our services at a pace that matches our long-term average increase in MHSA revenues.

- ⑦ As seen in the figure below, which depicts actual revenues and expenditures for FY2011-19 and the latest projections for FY2019-23, San Francisco's expenditures increase an average of \$1 million per year, which matches the average annual increase of MHSA revenues.

Year-over-year, MHSA revenues endure a great deal of volatility, as evident below. Despite this volatility, our services have been growing at a consistent and reliable rate. With this strategy, we expect to provide the same level of care to our MHSA clients despite the economic recession that was triggered by COVID-19.



Further, in planning for FY 2020-23 MHSA programming, the department held 19 community planning process (CPP) meetings that resulted in a mindful expansion of mental health services for the upcoming three-year term. The CPP is a cornerstone of MHSA’s mission and allows our programming to be a reflection of our community’s wants and needs. These expanded services include a steady increase to our mental health workforce development and training programs, the completion of a \$3 million capital project to better integrate our behavioral health services into a primary care clinic that serves the historically underserved Bayview-Hunters Point neighborhood, the transition of several successful Innovation programs to our MHSA core program, and the launch of two new Innovations programs.

San Francisco also supports an expedited process for obtaining Mental Health Services Oversight and Accountability Commission approval to execute Innovation programs. A speedy approval process for MHSA Innovation programs will prevent delays in spending and expedite access to these innovative programs by our community.

Despite the assertion in the report, San Francisco MHSA funds are not “unspent,” but rather dedicated to existing programs/innovations over the next three years or reserved to preserve our services in times of economic recession, such as we are currently experiencing. This fiscal prudence will allow us to continue important services to underserved and disenfranchised populations in the face of our current medical and economic crises.

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Thank you for the opportunity to share our experiences and respond to the recommendations in the report.

Sincerely,



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Director of Health
San Francisco Department of Public Health



Shireen McSpadden
Executive Director
Department of Disability and Ageing Services

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM SAN FRANCISCO COUNTY

To provide clarity and perspective, we are commenting on San Francisco's response to our audit. The numbers below correspond to the numbers we have placed in the margin of San Francisco's response.

As we discuss in Chapter 1—beginning on page 17—we reviewed the involuntary hold criteria in the LPS Act and determined that they provide designated professionals sufficient authority to treat individuals in need of involuntary treatment under the LPS Act. Our review of case files also found that designated professionals in the three counties we audited applied the definition of grave disability in a consistent manner. Based on the evidence, we did not conclude that the grave disability criterion needed any clarification.

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San Francisco had not shared this information with us before responding to our final draft report. We look forward to reviewing San Francisco's progress in implementing this recommendation when it responds further during our post-audit follow up.

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Although San Francisco identifies Zuckerberg as its primary designated treatment facility, we note on page 34 of our report that Zuckerberg is one of several designated treatment facilities in the county, and more than half—about 56 percent—of individuals leaving involuntary holds were leaving facilities other than Zuckerberg. In light of that, we are encouraged that the county agrees with our recommendation to adopt a systemic approach to identifying individuals placed on multiple involuntary holds at all designated facilities and connecting them to ongoing services.

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We found that many of the individuals we reviewed were enrolled in Medi-Cal, not in private health care insurance, and thus the county had responsibility for providing those individuals with services. As we explain on page 34 of our report, the presence of private insurance options for some individuals does not change our conclusion that a significant number of people, including those who were eligible for county services, experienced multiple involuntary holds but were not connected to intensive outpatient treatment.

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We agree that it is important to quickly share information about individuals who have been placed on involuntary holds. Treatment facilities are required to report to Justice about involuntary treatment holds within 24 hours of applying the hold and Justice updates its related data on a daily basis. We believe Justice's existing data can be shared quickly and efficiently so that counties can make important treatment decisions.

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- ⑥ We appreciate the county's perspective on the value of the engagement period for assisted outpatient treatment. As we describe on page 45, before a court can compel an individual to participate in assisted outpatient treatment the county must be able to demonstrate that it offered individual assisted outpatient treatment services and that the individual failed to engage in treatment. San Francisco informed us that the minimum length of this period was 30 days. We stand by our conclusion on page 45 that the engagement period could slow access to treatment for individuals who need treatment. In addition, as we describe in the section of our report beginning on page 46, we believe undelayed access to assisted outpatient treatment for individuals exiting conservatorship could improve outcomes for such individuals.
- ⑦ The county did not provide this graphic to us before submitting its response to our report, and therefore we have no comment about the accuracy of the graphic and the information it provides about MHSA funds. We specify on page 55 that counties may have unspent funds that they have already allocated to future planned uses.