COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

OFFICE OF THE DIRECTOR

November 29, 2012

TO: Office of the Mental Health Commission

FROM: Marvin J. Southard, D.S.W.
Director

SUBJECT: **ANALYSIS AND STAKEHOLDER COMMENTS ON THE LANTERMAN PETRIS SHORT (LPS) TASK FORCE II RECOMMENDATIONS**

The attached document contains a structured analysis of the 14 recommendations made by the LPS Task Force II: The Case for Updating California's Mental Health Treatment Law (http://www.lpsreform.org/LPSTF2.pdf), and additionally includes comments from various stakeholders. It may serve as a useful resource for those considering changes to LPS.

To produce the document, the Los Angeles County Mental Health Commission (MHC) and the Los Angeles County Department of Mental Health (DMH) invited community stakeholders to send representatives to a group convened to provide input into a structured analysis developed internally by DMH of the LPS Task Force II recommendations. The analysis presents each recommendation and its possible impacts on clinical, programmatic, fiscal, legal, and individual issues. It is not intended to address the desirability of any particular recommendation.

The comments by representatives from different groups regarding these impacts, obtained during the stakeholder meetings, provide information on various stakeholder perspectives. As such, they do sometimes reflect views regarding the desirability of recommendations. The meetings provided an opportunity for an exchange of ideas and help shape and focus the comments. Thank you.

MJS:RS:hjr

Enclosure: DMH Workgroup and Stakeholder Analysis - LPS Taskforce II Report Recommendations response

Department of Mental Health Analysis of the LPS Taskforce II Report Recommendations

Recommendation #1:	**Define "Grave Disability" to address the individuals' capacity to make informed consent to treatment and assess their ability to care for their health and safety.**
Implication Area	**Comment(s)**
Clinical	Departmental Analysis: 1. As applied to WIC 5150, would require remarkably sophisticated training of all evaluating personnel to make this decision. 2. Would require a clinical definition of capacity to give informed consent for "care for health" and "care for safety." 3. Would have an effect on clinical procedures for obtaining subsequent informed consent for medical interventions, as capacity determination would presumptively be part of the record. 4. Would require identification of clinical assessment tools that permit reliable and accurate determination of capacity. Stakeholder comments: 1. Bioethicists' first job is to define capacity. So this is right on the mark. It protects people—medical beneficence. Bioethicist 2. Would require determination of capacity without sufficient social context. Client advocate 3. Would cause clients not to disclose circumstances to providers because of fear of involuntary treatment. Client advocate/service operator 4. Early career clinicians and trainees would have difficulty determining capacity due to lack of training. Client advocate/MH professional 5. This redefinition doesn't fit law enforcement work or training. It could cause law enforcement to opt for arrest instead of capacity determination, increasing potential for criminalization. Community Advocate/law enforcement officer 6. This could be clarified to apply instead to capacity determination for purposes of 5151(the evaluation for involuntary inpatient hospitalization), and not apply for 5150 by first responders. Member, Treatment Advocacy Coalition 7. It remains vague as to how one would make determinations about different capacities. NAMI member Written Comments: 1. First responders would only have to have a reasonable belief that an evaluation was necessary for the individual. Evaluation and determination of a need to retain for treatment would occur upon admission. In other words, no one would expect first responders to provide capacity determinations for informed consent under 5150. This new definition would apply upon WIC 5151. This point requires clarification. Member, Treatment Advocacy Coalition 2. Clinicians would be expected to make recommendations about "capacity," without looking at the context in which behaviors occur and feelings are expressed which could lead to inaccuracies of assessment. Client Advocate. 3. Would cause clients not to disclose their circumstances to their providers for fear of being individually detained. Clinicians would be making decisions without the best information from their patients, which causes "bad treatment" as patient's symptoms are needed for diagnosis and treatment. Client advocate 4. Dementia (or the DSM-5 neurocognitive disorder) should be explicitly recognized as a mental illness that qualifies for LPS conservatorship. Currently, it is not uniformly considered in this fashion by California counties. Bioethicist

Recommendation #1:	**Define "Grave Disability" to address the individuals' capacity to make informed consent to treatment and assess their ability to care for their health and safety.**
Implication Area	**Comment(s)**
Programmatic:	Departmental Analysis: 1. Would significantly change necessary training for peace officers and other authorized responders in order to make clinical evaluations regarding capacity. 2. Would significantly change hiring needs for some programs that currently assess 5150 using personnel not trained in healthcare capacity decisions. 3. Would likely limit ability to perform subsequent medical interventions without judicial intervention for individuals termed "gravely disabled" under this definition, since lack of capacity would have been documented. 4. If capacity is determined upfront and authority provided to the surrogate decision maker, it could make it easier to obtain efficient and effective health care. Stakeholder Comments: 1. Deciding capacity is not something that first responders can do. They have no such training or ability. Patients' rights advocate/attorney Written Comments: 1. See previous note for clinical implications. Member, Treatment Advocacy Coalition 2. Officers in the field not being able to make assessments regarding informed consent. 3. Should include fire department/paramedics as specific intended to respond as 1st level. Community Advocate/law enforcement officer 4. Police should not be responsible for clinical evaluations. Community Advocate/law enforcement officer 5. Police arrest versus 5150 process will default to arrest as expeditious resulting to more clients in jails and courts. Community Advocate/law enforcement officer 6. Develop [Psychiatric Mobile Response Teams] PMRT's to accommodate the needs of the geographical jurisdiction. Community Advocate/law enforcement officer
Implication Area	**Comment(s)**
Fiscal:	Departmental Analysis 1. Would likely increase programmatic expenses by requiring higher levels of training for staff that assess for grave disability. 2. Would likely increase programmatic expenses for engaging judicial processes for subsequent medical interventions. 3. Would significantly increase expenses for clinical time and resources necessary to determine and properly document capacity. 4. Increasing the complexity and length of forensic due process and capacity hearings, increases the expense of clinician participation in forensic processes. Stakeholder comments: 1. Would cost programs more money. Client advocate/service provider

Recommendation #1:	**Define "Grave Disability" to address the individuals' capacity to make informed consent to treatment and assess their ability to care for their health and safety.**
Implication Area	**Comment(s)**
Fiscal: (continued)	Written Comments 1. One of the goals of this recommendation is "to provide treatment before tragic social, criminal justice and/or medical consequences occur." Not treating individuals creates the need for the most expensive and restrictive form of (continued) acute hospital care, and cost-shifting to the criminal justice system. Member, Treatment Advocacy Coalition 2. Wrong treatment or ineffective treatment would be costly + make treatment and trust building. 3. Increase stress of people seeking treatment because of fear being involuntarily held would lead to over treatment. 4. Cost would be substantially increased and could not be funded by the MHSA due to the involuntary nature of the care. Client Advocate
Implication Area	**Comment(s)**
Legal/Legislative:	Departmental Analysis 1. Would require legislative action to change WIC 5000. 2. Would raise "determination of capacity" issues for all individuals detained under the new definition of gravely disabled. 3. May significantly increase the length and complexity of hearings related to determination of grave disability on the basis of capacity. 4. Would raise constitutional issues regarding personal right of liberty and substantive "Due Process" under U.S. Constitution, Amendments 5 and 14 (a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends), and California Constitution §7(a)? 5. Would likely increase complexity and length of due process and capacity hearings. 6. Would likely require evaluation of a large body of case law about the issue of capacity as a basis for involuntary detention. Stakeholder Comments 1. But the current wording says this applies to 5150. These criteria are overly broad and likely would be unconstitutional. (e.g. Hawaii's was struck down.) Isn't a definition that can be utilized by judiciary or first responders. They are obligatory, and will bog down court, as there is no global description of capacity. Hearings will be longer with more factors. Would effectively slow down process by 50%. Mental Health Counselor/court administrator 2. Impact on courts and legal processing. Community Advocate/Attorney 3. Could cause people to incriminate themselves. Client advocate/service provider 4. Judges have no ability to determine "anasognosia." Client advocate Written comments: 1. One of the goals of this recommendation was to "offer practical guidelines" and "include more comprehensive details such as the probability the person would experience substantial bodily harm, serious illness, significant psychiatric deterioration or debilitation without adequate treatment." Member, Treatment Advocacy Coalition

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Implication Area	**Comment(s)**
Legal/Legislative: (continued)	Written Comments (continued) 2. Judges and others have no way of determining the presence of "anasognosia – a neurological term used by persons like Dr. Oliver Sachs and not appropriate for use in determining informed consent or capacity of people with psychiatric diagnoses. Client Advocate
Implication Area	**Comment(s)**
Individual Impact:	Departmental Analysis: 1. Would decrease autonomy to make personal healthcare and lifestyle decisions. 2. Would increase autonomy regarding decisions about finding food, clothing, and shelter in cases where such decisions do not involve healthcare and safety. Stakeholder Comments: 1. Could cause individuals to avoid disclosing treatment needs for fear of losing civil rights. Client advocate Written Comments: 1. Would cause people to avoid contact with the mental health system. 2. Increases stress levels of people seeking treatment who do not want to lose their civil rights, thus aggravating their symptoms of mental illness.

Recommendation #2:	**Adopt concurrent legal processes to determine probable cause for hospitalization and capacity to refuse medication in one hearing**
Implication Area	**Comment(s)**
Clinical:	Departmental Analysis: 1. Would likely increase efficiency of clinician activities. Stakeholder comments: 1. Med hearing should not be done on an expedited basis before there is a chance for individual to fully consider consenting. Client advocate/service provider
Implication Area	**Comment(s)**
Programmatic:	Departmental analysis: 1. Would likely increase efficiency of program planning Stakeholder comments: 2. Legally this may make sense, but common sense makes this highly problematic because we presume there is something wrong. Bioethicist 3. There is an inadequate number of qualified prescribers to staff programs for this. Clinician administrator 4. This recommendation is important, because delaying treatment might deny effective treatment during the time-limited course of the hospitalization. In some counties, the delay of Reise is significant. Member, Treatment Advocacy Coalition Written comments: 1. Although the consensus in the room was that patients are not held for periods of time that were too long in Los Angeles County, the reason why was not thoroughly examined. Is it because our Los Angeles system is a model of efficiency, or does our county simply release many patients too soon to fully recover from mental health episodes which only serves to lead to further "revolving door" system behavior? This keeps the bed capacity more fluid, but are patients being well served by our process? Member, Treatment Advocacy Coalition 2. Doctors not seeing patients for medication/ consent
Implication Area	**Comment(s)**
Fiscal:	Departmental analysis 1. Would likely decrease programmatic costs associated with judicial processes 2. May decrease the costs associated with hospitalization by shortening the length of stay to the extent that it was determined by a wait for treatment. Stakeholder comments 1. Will double costs for court and for physicians. Will have capacity for half the number of hearings. Mental Health Counselor/court administrator 2. Patients' rights would need expansion to provide hearing. Patients' rights officer 3. We should remember that having medication in every hearing isn't a given here. Client advocate/service provider 4. We wouldn't have to do med refusal on every hearing. Member, Treatment Advocacy Coalition

Recommendation #2:	**Adopt concurrent legal processes to determine probable cause for hospitalization and capacity to refuse medication in one hearing**
Implication Area	**Comment(s)**
Fiscal: (continued)	Written comments: 1. It is inconsistent for the court, on the one hand, to emphasize the estimated potential increases in costs that the court believes would arise from implementation of Recommendation #1, but does not analyze the potential court savings of combining hearings that could offset such costs. In fact, no analysis was provided at all on Recommendation #2 of potential savings. When recommendations seek to save money, it seems to be given less weight than when the court implies that a recommendation would increase costs. Member, Treatment Advocacy Coalition 2. Double staff at Courts systems - $/time (2800 combined hours).
Implication Area	**Comment(s)**
Legal/Legislative:	Departmental analysis: 1. Would require statutory changes to permit a single hearing for detention and medication. 2. Would require resolution of any inconsistencies of statutory P.C. hearing officer and Riese hearing officer 3. Inconsistency between initiating party in PC hearings and Riese hearings must be resolved. Stakeholder comments: 1. Doctors would have to testify at every hearing. This is difficult. Mental Health Counselor/court administrator 2. A space between the hearings creates a space for doctors to talk to their patients, and creates incentive for doctors to talk to their patients. Patients' rights advocate/attorney 3. Presumes the need to have a hearing, whereas the law presumes capacity. What if person loses capacity later, and we are stuck because hearing was already held. Mental Health Counselor/court administrator
Implication Area	**Comment(s)**
Individual Impact:	Departmental Analysis: 1. May generate increased fear of extended involuntary detention and treatment by individuals who experience the combined hearing as a threat. Stakeholder comments: 1. Patients should be presumed competent. This combines hearings of different focus. Client advocate 2. Trust and relationship with physician may be the most potent tool; going to involuntary medication via hearing could harm this. Early hearing gets in the way. Client advocate/service provider Written Comments 1. Care should be taken to ensure that hospitalization and medication hearings not be compromised in combing them. One should not necessarily lead to the other. Client Advocate 2. Patients are presumed competent until determined otherwise. This presumes "lack of capacity" and combines hearings that are essentially different in focus which would lead to decrease of individual rights. Client Advocate

Recommendation #3:	**Conform initial acute care hospital certification periods to 28 days, renewable for 28 days. Consider less restrictive alternatives to hospitalization at each hearing or upon renewal of holds.**
Implication Area	**Comment(s)**
Clinical:	Departmental Analysis: 1. Would likely provide more time for clinical treatment of involuntarily detained individuals. Stakeholder Comments: 1. It won't have much clinical impact, in that 7 days is currently the average length of stay (ALOS), and that's already shorter than a 14 day hold. Patients' rights advocate/attorney 2. Will cause longer stays, because clinical work will not be as accelerated. Client advocate/service provider Written comments: 1. Treating patients without premature discharges based on non-clinical pressures (fiscal, etc.) should promote more positive outcomes and lower readmission rates over time. Member, Treatment Advocacy Coalition 2. Cause people to be held longer as "the time to accomplish a task expands to the time allocated to the task" 3. People will be treated at more restrictive level.
Implication Area	**Comment(s)**
Programmatic:	Departmental Analysis: 1. Would likely increase resource demands on programs providing involuntary commitment by increasing the number of individuals detained who would have been released earlier if given choice.
Implication Area	**Comment(s)**
Fiscal:	Departmental Analysis: 1. Would likely increase expenses associated with involuntary detention through longer commitments for individuals who would have been released earlier if given choice. 2. Would likely increase the total number and the complexity of judicial hearings and associated clinical/social work for purposes of determination of alternative treatment. Written comments: 1. Providing sufficient time for clinicians to stabilize an individual should lower readmission rates and begin to ameliorate the "revolving door" of our mental health system. This could ultimately reduce demands on resources. This could also reduce unnecessary hearings and fiscal stress on the courts which could be a significant factor in reducing costs. Member, Treatment Advocacy Coalition 2. Increase in expenses as more people are held longer. 3. Increases cost, lack of beds. Client Advocate 4. Medical systems may be drained by people being kept up to 2 months (59 days). In the past people were being held on a 5150 often – the system determined the expense was prohibitive and crisis outreach teams now attempt to keep people in community if possible. Client Advocate

Recommendation #3:	**Conform initial acute care hospital certification periods to 28 days, renewable for 28 days. Consider less restrictive alternatives to hospitalization at each hearing or upon renewal of holds.**
Implication Area	**Comment(s)**
Legal/Legislative:	Departmental Analysis: 1. Would require legislative action to change WIC 5000. 2. Would require a clarification of the need to make such changes in light of the existence of current code and 5270.10 (30 day certification) 3. Would require clarification of the effect of these changes on time frames necessary for LPS conservatorship processes. 4. Would require new statement of legislative intent regarding purpose of involuntary detention, in order to clarify what "renewable" means. Stakeholder Comments: 1. Uniform use of the existing 30 day certification criteria in all counties would accomplish the same purpose. Deputy public guardian 2. Would require clarification of the interaction with temporary conservatorship. Deputy public guardian 3. Would require clarification of the effect on the time allotted for the public guardian to complete legal mandates. Deputy public guardian 4. It is not clear if it is an additional certification or a "renewal." What is a "renewal," and does this give the patient the right to a hearing. Mental Health Counselor/court administrator 5. Longer duration of detention will cause more writ appeals to go to court, because patients will be more upset. Mental Health Counselor/court administrator Written Comments: 1. Increase writ appeals to courts. Client Advocate
Implication Area	**Comment(s)**
Individual Impact:	Departmental analysis: 1. Would decrease autonomy by increasing the length of time an individual could be involuntarily committed without additional judicial recourse. 2. Would reduce the ability to seek judicial relief. Stakeholder Comments: 1. Goes against "hope, recovery and wellness" by decreasing client involvement in processes to get them out. Patients' rights advocate 2. It is not clear that the duration of hold would correspond with duration of hospitalization, which could be unethical. NAMI member 3. Creates incarceration atmosphere rather than treatment. Client advocate. Written Comments: 1. Could cause individuals to feel "incarcerated" rather than cared – focus on illness rather than moving person back into the community as quickly as possible (Olmstead Act). Client Advocate 2. Increased hostility and fear among clients to doctors and providers. Client Advocate 3. People held longer will resist seeking mental health treatment in the future.

Recommendation #4:	**Establish criteria for an LPS conservatorship to be "grave disability" as defined under Recommendation # 1 of this report. Establish conservatorships by clear and convincing evidence. Revise procedures to allow for efficient application and due process for conservatorships applied for from community settings.**
Implication Area	**Comment(s)**
Clinical:	Departmental Analysis: 1. Same as for Recommendation #1: Would require a clinical definition of capacity for "care for health" and "care for safety." 2. Same as for Recommendation #1: Would have effect on clinical procedures for obtaining subsequent informed consent for medical interventions, 3. Potential decrease in judicial approval of conservatorship applications, due to increased difficulty of demonstrating grave disability criteria in an individual not involuntarily detained. Stakeholder comments: 1. Capacity is an ethical way to find a surrogate decision-maker in the public guardian, and therefore will allow clinicians to better address the needs of their patients, especially for med/psych patients. Bioethicist 2. Collection of evidence to do conservatorships will require much work within community, which could be impossible, instead of being in confines of hospital and using observational tools. Client advocate/service provider 3. Keeping a person in an involuntary setting in order to get conservatorship doesn't seem right. Client advocate/service provider Written Comments 1. Clinicians' time would be used searching for evidence of "grave disability" as those not involuntarily detained would not have the hospital's 24/7 records to establish "grave disability."
Implication Area	**Comment(s)**
Programmatic:	Departmental Analysis: 1. Increase in administrative efficiency for efforts directed toward individual applications. 2. Decreased use of acute inpatient hospitalization related to this activity. 3. Potential increase in applications due to expanded criterion for capacity, which could increase resource demand in community settings and in PG and judicial systems. Stakeholder Comments: 1. Increase in conservatee caseloads would burn out conservators. Patients' rights advocate 2. Changing the standard to capacity will essentially involve every DPG as a substitute decision-maker for everything, which does not happen now. Patients' rights advocate/attorney 3. Saying that current service resources are inadequate to accomplish this doesn't invalidate the idea; might simply suggest more resources necessary. Bioethicist 4. Could affect hospitals' ability to transfer to lower levels of care during conservatorship process. Local hospital association representative 5. Application from lower level of care could negatively impact chances of getting a conservatorship. Deputy public guardian.

Recommendation #4:	**Establish criteria for an LPS conservatorship to be "grave disability" as defined under Recommendation # 1 of this report. Establish conservatorships by clear and convincing evidence. Revise procedures to allow for efficient application and due process for conservatorships applied for from community settings.**
Implication Area	**Comment(s)**
Fiscal:	Departmental Analysis: 1. Decreased costs associated with acute psychiatric hospitalization for purpose of establishment of conservatorship. 2. Increased costs to mental health programs, Public Guardian, and judicial officers related to processing increased number of conservatorship applications. 3. Significant expansion of numbers of people for whom conservatorship would be available.
Implication Area	**Comment(s)**
Legal/Legislative:	Departmental Analysis: 1. Would require legislative action to change WIC 5000. 2. Same as Recommendation #1: Would likely limit ability to perform subsequent medical interventions without judicial intervention for individuals termed "gravely disabled" under this definition. 3. Raises CA constitutional issues regarding burden of proof. 4. Raises issues of payment for mandatory sub-acute and residential care for eating disorders. Stakeholder comments: 1. The 1 year duration requires clear and convincing evidence, something decided by US Supreme Court and CA, too. Mental Health Counselor/court administrator 2. Conservatorship letters are already valid from county to county, so statement in LPS taskforce is incorrect. Deputy public guardian 3. Could make it more difficult to get off conservatorship. Client advocate Written comments: 1. Treatment decisions should not be held to a criminal standard of "beyond a reasonable doubt." This is not only a more appropriate standard, but should contribute to the reduction of stigma. Member, Treatment Advocacy Coalition
Implication Area	**Comment(s)**
Individual Impact:	Departmental Analysis: 1. Same as Recommendation #1: Would decrease autonomy to make personal healthcare and lifestyle decisions 2. Same as Recommendation #1: Would increase autonomy regarding decisions about finding food, clothing, and shelter in cases where such decisions do not involve healthcare and safety. Stakeholder Comments: 1. Hurts relationships and distances patients from clinicians due to loss of control. Patients' rights advocate 2. Clear and convincing evidence sells consumers short. Client advocate 3. Conservatorships are not intended to interfere with individual determination; the conservator is supposed to operate under what conservatee wants. Patients' rights advocate/attorney 4. Anyone who can't keep themselves safe could be called gravely disabled. Client advocate/service provider

Recommendation #4:	**Establish criteria for an LPS conservatorship to be "grave disability" as defined under Recommendation # 1 of this report. Establish conservatorships by clear and convincing evidence. Revise procedures to allow for efficient application and due process for conservatorships applied for from community settings.**
Implication Area	**Comment(s)**
Individual Impact: (Continued)	Written Comments: 1. Would lessen opportunities for mental health consumers/clients to demonstrate "capacity" due to recommendations that conservatorship be established by "clear and convincing evidence" possibility provided by application "from community settings" – (Implies focus on deficits and disability and refusal to addresses strengths and abilities). Client Advocate 2. Any mental health consumer who is a victim of a crime could be conserved under this recommendation.

Recommendation #5:	**Authorize an additional 90 day certification to continue acute care hospitalization for individuals who meet the demonstrated dangerousness standard in WIC 5300, with a right of appeal. Provide notice of application for impending post certification commitment under WIC 5300 to County District Attorneys and Public Defenders 30 days before expiration of the 90 day certification. Commitment should be for one year, renewable, with the relevant historical course of the individual's illness considered during the trial, and demonstrated danger established by clear and convincing evidence.**
Implication Area	**Comment(s)**
Clinical:	Departmental Analysis: 1. Increases the need to define ongoing and lengthy clinical intervention for individuals hospitalized for non-therapeutic reasons. 2. Potentially exposes vulnerable patients treated in acute inpatient settings to injury by individuals detained for lengthy periods for dangerousness. 3. Would likely strongly influence clinical treatment decisions by creating greater concerns by clinicians regarding liability exposure by discharging individuals with failure to predict dangerousness at a later date, rather than discharging based upon lack of specific history. 4. Likely would require that cause of dangerousness be a mental disorder other than a personality disorder in order to conform to other existing statutes. 5. Likely diagnostic requirement of establishing person has serious difficulty in controlling his or her dangerous behavior Stakeholder Comments: 1. Why 90 days, simply for dangerousness? Patients' rights advocate/attorney 2. People up for renewal are more violent. So are more certifications a good idea, as they generate more assaults. NAMI Member
Implication Area	**Comment(s)**
Programmatic:	Departmental Analysis: 1. Would likely increase use of acute inpatient beds for this purpose, thereby limiting their availability for clinical treatment. 2. Would likely change program policies in order to limit liability. 3. Would likely change program policies by markedly changing the population on acute inpatient units to a group of dangerous individuals detained for prolonged periods. 4. Would shift program and costs from criminal justice and public guardian to mental health systems. Stakeholder Comments: 1. Could provide a sort of conservatorship that LPS doesn't allow for. Deputy public guardian 2. But mental health system would substitute for criminal justice system as a way to manage violence. Patients' rights advocate/attorney
Implication Area	**Comment(s)**
Fiscal:	Departmental Analysis: 1. Would likely significantly increase costs for acute inpatient hospitalization for individuals detained under WIC 5150 criterion of Danger to Others. 2. Would likely increase costs associated with mitigating danger on acute inpatient psychiatric units through increased staffing and hardening of structure. 3. Would likely increase costs associated with liability of patient injuries on acute inpatient psychiatric units caused by dangerous individuals detained for prolonged periods.

Recommendation #5:	**Authorize an additional 90 day certification to continue acute care hospitalization for individuals who meet the demonstrated dangerousness standard in WIC 5300, with a right of appeal. Provide notice of application for impending post certification commitment under WIC 5300 to County District Attorneys and Public Defenders 30 days before expiration of the 90 day certification. Commitment should be for one year, renewable, with the relevant historical course of the individual's illness considered during the trial, and demonstrated danger established by clear and convincing evidence.**
Implication Area	**Comment(s)**
Fiscal: (continued)	Departmental Analysis: (continued) 4. Significant increase in costs of judicial hearings and related expenses for this purpose.
Legal/Legislative:	Departmental Analysis: 1. Would require legislative action to change WIC 5000 (5300 and possibly other sections). 2. Would likely raise civil liability issues regarding exposure of vulnerable mentally ill individuals to dangerous individuals in acute psychiatric inpatient settings. 3. Would raise constitutional, due process and equal protection issues.
Implication Area	**Comment(s)**
Individual Impact:	Departmental Analysis: 1. Would likely decrease personal autonomy for dangerous individuals initially detained under WIC 5150 in acute psychiatric hospitals.

Recommendation #6:	**Adopt a statewide standardized form to record the historical course of a person's illness.**
Implication Area	**Comment(s)**
Clinical:	Departmental Analysis: 1. Would likely improve and standardize clinical recording of course of illness. Stakeholder Comments: 1. Bias is introduced by this information. Patients' rights advocate 2. Would be useful if it involves family input. Client advocate/MH professional 3. The content of the form is critical. The questions should be clearly formed and should have relevant history. Client advocate/service provider 4. Follows AB24, which says that historical course shall be used when available. NAMI developed such forms. But no consensus on content or use of forms. This mandates it. Families would use it. Member, Treatment Advocacy Coalition 5. Supportive. Hard to see how more info hurts clinical process. But should have safeguards that other clinical record elements have. Patients' rights advocate/attorney 6. Hearing officers love more information. So this is good. Will affect conservatorship or other hearings where rules of evidence apply. So it will be complicated in anything but probable cause hearings. Mental Health Counselor/court administrator 7. Who fills it out is important. Should be three different parties: patient, family, and doctor. Client advocate/service provider 8. Law enforcement agencies would sign on if form is simple and easy. Tailored to first responders like fire and EMT. Community advocate/law enforcement officer 9. If the information is to be used in a hearing, the patient should have a right to review before hearing. NAMI Member 10. Bridge to EHR must be clear. Filling this out shouldn't be seen as gate into other info. Client advocate Written Comments: 1. Cause clinicians to wrongly view family members' input due to the questions asked on the form that otherwise would not occur to family's view.
Implication Area	**Comment(s)**
Programmatic:	Departmental Analysis: 1. Would require programmatic changes to meet uniform standards for acquisition and recording of course of illness. 2. Would require programmatic work to integrate with Electronic Health Records (EHRs). Stakeholder Comments: 1. Training would be a challenge for use of form. Community advocate 2. Access as described by so many agencies is dangerous and violates confidentiality. Client advocate Written comments: 1. Although passed in 2002, AB 1424 is rarely used. Local agencies are hesitant to utilize an AB 1424 form that is not officially sanctioned by the county or state. California should seek to develop a standardized AB 1424 form that would be accepted statewide. Member, Treatment Advocacy Coalition

Recommendation #6:	**Adopt a statewide standardized form to record the historical course of a person's illness.**
Implication Area	**Comment(s)**
Fiscal:	1.
Implication Area	**Comment(s)**
Legal/Legislative:	Departmental Analysis: 1. Would require determination of the extent and manner in which such information is used in conservatorship matters. 2. May raise questions about admissibility and confrontation of witnesses Written Comments: 1. AB421 Forms: All first responders, including fire departments, to use form.
Implication Area	**Comment(s)**
Individual Impact:	Stakeholder Comments: 1. Could allow individual to understand how others see him/her. Client advocate Written Comments: 1. Could provide individual with access to information that could be contested and possibly amended if inaccurate. Client Advocate 2. Might cause individual who has changed to be seen and judged by past behavior not current capacity.

Recommendation #7:	Develop local systems of interagency coordination to ensure timely transportation and placement in facilities appropriate to the person's needed level of care.
Implication Area	**Comment(s)**
Clinical:	Departmental Analysis: 1. Depending upon nature of interagency coordination referenced, may require additional clinical assessment and documentation related to determination of proper facility for specific care requirements. Stakeholder Comments: 1. Clients should be transferred in ambulances, not police cars. Community advocate/law enforcement officer 2. Non-designated facilities are key factors to address in the placement aspects of this. Local hospital association representative 3. There is chaos in county transportation systems related to who may release hold, how to get authorization to pay, and whether emergency medical services or fire department may transport individuals in 5150 custody. The intent of this is to examine problems and develop a coherent plan. Member, Treatment Advocacy Coalition 4. Facilities close to incident should be required to accept them. And transport should be undertaken in humane way. Community/Family advocate 5. Non-LPS settings are inappropriate transport destinations. Effort is to coordinate away from non- LPS designated emergency facilities. Member, Treatment Advocacy Coalition 6. Choice should be broader than between police cars and ambulance; what about passenger cars? Client advocate/service provider 7. Non-LPS designated facilities should have authorized staff to do triage and transfer. Local hospital association representative 8. Would need to determine placement decisions in environment of limited resources; e.g. no inpatient psychiatric beds. Clinician administrator 9. Interagency savings should be captured and appropriately distributed. Patients' rights advocate/attorney
Implication Area	**Comment(s)**
Programmatic:	Departmental Analysis: 1. Will likely require more detailed definitions of goals, requirements, and key elements of interagency coordination in order to operationalize. 2. Depending upon nature of interagency coordination referenced, may impact procedures in various agencies and necessitate negotiation or re-negotiation of a variety off interagency agreements.
Implication Area	**Comment(s)**
Fiscal:	Departmental Analysis: 1. Depending upon nature of interagency coordination referenced, may have significant fiscal implications for participating agencies, likely increasing costs for some and decreasing costs for others. 2. Depending upon nature of interagency coordination referenced, will likely necessitate agreements regarding agency responsibilities for funding transportation and placement. Written Comments: 1. Passenger cars should be used when appropriate.

Recommendation #7:	**Develop local systems of interagency coordination to ensure timely transportation and placement in facilities appropriate to the person's needed level of care.**
Implication Area	**Comment(s)**
Legal/Legislative:	Departmental Analysis: 1. Depending upon nature of interagency coordination referenced, may require legislative action to change the manner in which facilities are LPS designated to detain individuals involuntarily. 2. Depending upon nature of interagency coordination referenced, may involve legal decisions regarding responsibility of various facilities to accept interagency coordination directives. Stakeholder Comments: 1. A question of who has the right to release hold is behind this recommendation and should be explicitly addressed. Client advocate 2. Must assure that whatever transportation and placement is used should be safe and secure. Patients' rights advocate Written Comments: 1. Who has right to "release the hold"? Client Advocate
Implication Area	**Comment(s)**
Individual Impact:	Departmental Analysis: 1. Depending upon nature of interagency coordination referenced, would likely decrease personal autonomy to the extent that decisions arising from interagency coordination are counter to the wishes of a person being treated. Stakeholder Comments: 1. The transportation system should take a detained person to a place that can immediately evaluate for need to hold. Client advocate 2. Van transport was better than ambulance because it didn't imply need for hospitalization as greatly. Client advocate 3. Race and culture play a role; An African American being transported in a police car has cultural implications. Client advocate/service provider 4. System failures are the issue; not people failures. Client advocate/service provider Written Comments: 1. "Interagency coordination… appropriate level of care"? How do we determine that before the fact? Timely transportation is helpful as long as it takes person to a place where person is evaluated as to whether he or she <u>needs</u> to be "placed" in any "facility" (Puts the cart before the horse). Client Advocate 2. May be determined to be released to community. Client Advocate 3. May be determined to be sent to an Urgent Care Center. Client Advocate 4. May be determined to be admitted to hospital for evaluation (72 hour hold). Client Advocate 5. Police cars are not acceptable. Ambulance is okay but passenger cars might be appropriate. 6. This would not decrease personal autonomy. What could possibly decrease personal autonomy more than being handcuffed and placed in the back of a police patrol car? Transportation provided in the most appropriate manner for an individual should decrease feelings of stress, trauma, and feelings of being treated like a criminal when other options besides police transport are available and appropriate. Member, Treatment Advocacy Coalition

Recommendation #8:	**Ensure Medi-Cal definitions for voluntary and involuntary hospitalization are consistently defined, monitored and applied. Appeals should conducted by a neutral third party.**
Implication Area	**Comment(s)**
Clinical:	Departmental Analysis: 1. Depending upon nature of appeals process, could have clinical implications. Stakeholder Comments: 1. Long Beach: Takes power from clinical team if criteria for appeals are known. Ambulances demand holds. Community advocate/city administrator Written Comments: 1. Does the current appeals process create financial incentives to prematurely discharge patients which can increase the likelihood of negative outcomes? It is a fair question to ask. Member, Treatment Advocacy Coalition
Implication Area	**Comment(s)**
Programmatic:	Departmental Analysis: 1. Would need to define what Medi-Cal definitions are referenced, as no obvious definitions for voluntary and involuntary hospitalizations appear in the Medi-Cal regulations. 2. Would need to identify the nature of appeals process, the goal of appeals, the parties to the appeals, the mechanisms regarding third party selections, and the material effect of third party decisions. 3. Depending upon nature of appeals process, would require development of policies and procedures in agencies involved. 4. Would require identification of involuntary services that are and are not covered services under Medi-Cal Plan. Stakeholder Comments: 1. Must separate out the issues of LPS reform and fiscal reform, as they are clearly different and can be confused with each other. Patients' rights advocate/attorney 2. Patients' rights issues are raised if criteria for payment require involuntary hold. Patients' rights advocate 3. Task force felt that current definition of Medical Necessity isn't clinically appropriate to input. Member, Treatment Advocacy Coalition 4. The nature of the "neutral" third party would be critical. Client advocate 5. Administrative day rates would be affected if involuntary detention conflicts with Medi-cal medical necessity criteria. Local hospital association representative 6. How can we analyze, if no definitions exist in Medi-cal medical necessity for voluntary vs. involuntary. Community/patient advocate

Recommendation #8:	**Ensure Medi-Cal definitions for voluntary and involuntary hospitalization are consistently defined, monitored and applied. Appeals should conducted by a neutral third party.**
Implication Area	**Comment(s)**
Fiscal:	Departmental Analysis: 1. May increase Medi-Cal costs for hospital services depending on changes to Medi-Cal medical necessity criteria 2. Depending upon nature of appeals, would require funding for operation of such systems. Stakeholder Comments: 1. We must get the payor out of appeals process, because the payor is biased. Member. Treatment Advocacy Coalition Written comments: 1. It is an appropriate question to ask: Should we take "the payor" out of the appeals process? Member, Treatment Advocacy Coalition
Implication Area	**Comment(s)**
Legal/Legislative:	Departmental Analysis: 1. Depending upon nature of appeals process, would have a variety of legal implications related to involuntary detention in LPS designated facilities. Stakeholder Comments: 1. Losing liberty over reimbursement issues would be dangerous. Patients' rights advocate/attorney 2. Linking involuntary treatment have fiscal implications could lead to danger. Client advocate
Implication Area	**Comment(s)**
Individual Impact:	Departmental Analysis: 1. Depending upon nature of appeals process, could increase or decrease personal autonomy. Written Comments: 1. The focus on payment (via Medi-Cal) rather than on appropriateness of the individual level of care creates a context where individual needs may be ignored.

Recommendation #9:	**Prioritize services to the most seriously disabled adults with a mental illness whether those services are needed on a voluntary or involuntary basis in the community or a hospital setting.**
Implication Area	**Comment(s)**
Clinical:	Departmental Analysis: 1. Would likely increase service availability to those adults meeting a defined standard of most severe disability, including effective clinical services that could decrease the level of disability. 2. Would likely decrease service availability to those individuals not meeting such a standard, including effective clinical services whose absence might cause worsening of the level of disability. 3. Would overlay clinical decision-making with legal rights to care based upon diagnostic assessment, and potentially lead to court hearings to resolve disputes. Stakeholder Comments: 1. This would limit resources for preventive services. Client advocate/service provider 2. This would make homelessness worse. Client advocate/service provider 3. This is a weakness-based, rather than strength-based program. Client advocate/service provider
Implication Area	**Comment(s)**
Programmatic:	Departmental Analysis: 1. Would likely expand programs that provide services for severely disabled adults. 2. Would likely decrease programs that provide services for individuals who are not severely disabled adults. 3. Would likely decrease the overall numbers of individuals to whom mental health services are provided, as fewer individuals (severely disabled adults) will use more of the services that would otherwise be provided to a larger number of less severely disabled individuals. Stakeholder Comments: 1. This could establish useful thresholds for necessary number of beds in a community. Member, Treatment Advocacy Coalition 2. This should not be a war between recovery and anti-recovery, essentially a zero-sum. Member, Treatment Advocacy Coalition 3. There is no data for determining necessary number of beds to prioritize; more beds could drive more hospitalization. It would be better to focus on entry-points into the system, rather than more beds. Community advocate/attorney 4. “Prioritize” means taking away from some to give to others. In this context, would mean taking resources away from children. Patients’ rights advocate/attorney 5. Senator. Steinberg said that only way that overall system can be stabilized is by prioritizing resources for earlier intervention—this runs contrary to that notion. Patients’ rights advocate/attorney

Recommendation #9:	Prioritize services to the most seriously disabled adults with a mental illness whether those services are needed on a voluntary or involuntary basis in the community or a hospital setting.
Implication Area	**Comment(s)**
Programmatic: (continued)	Written comments: 1. If comments #2 and #3 above are true, then it is an admission that we are currently purposefully decreasing programs that provide services for individuals who are the most severely disabled in order to protect funding for those who are less disabled. This is the wrong argument. A. These populations are served by different funding streams. B. There should be a minimum threshold of acute and sub-acute care available in all counties so more severely disabled individuals have access to the appropriate level of care, and C. Our mental health system and communities should not wage an ideological war of outpatient vs. acute care. ALL individuals with serious mental illness should receive access to the level of care that is required to appropriately serve them. Access may be determined to a great degree by resources, but all populations deserve at least some of the funding that is available. But our most ill individuals are continuing to get less and less every year. Member, Treatment Advocacy Coalition
Implication Area	**Comment(s)**
Fiscal:	Departmental Analysis: 1. Would likely require higher levels of funding for severely disabled adults. 2. Would likely decrease fiscal resources for individuals who are not severely disabled adults. Stakeholder Comments: 1. The cost of serving one person in a hospital is cost of serving eight in Full Service Partnerships (FSP). And there is elastic demand for inpatient beds. Client advocate/service provider Written Comments: 1. Hold FSPs financially liable when provider fails to respond to an acute care hospital within a designated time. Better alignment of financial incentives. Local hospital association representative
Implication Area	**Comment(s)**
Legal/Legislative:	Departmental Analysis: 1. To the extent that prioritization of services for severely disabled adults decreases services to other entitled populations, may have legal implications. 2. Would increase the bases for judicial and administrative hearings and decision-making regarding clinical determinations. 3. Could raise issues regarding access to treatment for minors. Stakeholder Comments: 1. We are already legally required to have acute inpatient capacity. County legislative analyst 2. There must be a strong connection between private hospitals and FSP. Community advocate/city administrator 3. Those people deprived of resources or rights (as not sufficiently severely ill) will create lawsuits and liability. Patient advocate

Recommendation #9:	**Prioritize services to the most seriously disabled adults with a mental illness whether those services are needed on a voluntary or involuntary basis in the community or a hospital setting.**
Implication Area	**Comment(s)**
Individual Impact:	Departmental Analysis: 1. No additional analysis Stakeholder Comments: 1. Could penalize people who have partially recovered and are now not so severely ill, as they could lose their priority and services. Client advocate 2. We must be sure that if we shift priority, the work does not fall to law enforcement to place more people on holds. Community advocate/law enforcement officer Written Comments: 1. The focus on “the most seriously disabled” as being the basis for providing prioritized services in the community as well as in a hospital setting creates a situation where people currently receiving services with MHSA funds might no longer be eligible for those services.

Recommendation #10:	**Implement Assisted Outpatient Treatment (Laura's Law) statewide.**
Implication Area	**Comment(s)**
Clinical:	Departmental Analysis 1. No additional analysis. Stakeholder Comments: 1. There is an increase in effectiveness of treatment when consent is required. Client advocate/service provider 2. The "black robe effect" compensates for lack of clinical powers in the law. Member, Treatment Advocacy Coalition Written comments: 1. Please review the results in Nevada County. "Nevada County has been awarded a 2011 National Association of Counties Achievement Award for the Assisted Outpatient Treatment Program at Turning Point Providence Center. (http://www.tpcp.org/Providence-Center). Member, Treatment Advocacy Coalition
Implication Area	**Comment(s)**
Programmatic:	Departmental Analysis: 1. Depending on the nature of implementation, would require development of AOT programs in each county. 2. Depending on the nature of implementation, would impact resources required for hearing in judicial system in each county. 3. Depending on the nature of implementation, would impact resources in local county departments of mental health to investigate requests and prepare applications and appeals. 4. Depending on implementation could decrease other involuntary treatment programs available in the implementing county. 5. Depending on decisions regarding potential eligibility of AOT for MHSA funding could impact other MHSA programs. Stakeholder Comments: 1. This would move appropriate people from criminal justice system to treatment system. Member, Treatment Advocacy Coalition 2. This would remarkably expand the burden on Mental Health courts. No such funding for this is available. Mental Health Counselor/court administrator 3. AOT programs are heavily dependent on residential capacity. County legislative analyst
Implication Area	**Comment(s)**
Fiscal:	Departmental Analysis: 1. Would require funding for AOT programs which may affect funding for other programs 2. Would require clarification of permissible funding streams for AOT and depending on the clarification could impact other programs. 3. Increase costs associated with necessary additional clinical and administrative staffing necessary to support initiation of proceedings. 4. Would significantly increase court and related costs for mental health related activities in superior courts

Recommendation #10:	**Implement Assisted Outpatient Treatment (Laura's Law) statewide.**
Implication Area	**Comment(s)**
Fiscal: (continued)	Stakeholder Comments: 1. We shouldn't be in boxes regarding money. We should simply determine if we need it, and then figure out who will pay. Community/Family advocate 2. Law enforcement would need to be included in resource allocation to manage such programs. Community advocate/law enforcement officer 3. We could recapture resources from jails. Patients' rights advocate/attorney 4. What about pent up demand preventing closure of jail resources? Community advocate Written comments: 1. Nevada County has calculated that they saved $1.81 for every $1.00 of cost. "Nevada County Behavioral Health and Turning Point's Assisted Outpatient Treatment Program won a 2010 CSAC Challenge Award for saving over $500,000 taxpayer dollars in two years by decreasing hospitalizations and incarcerations." Member, Treatment Advocacy Coalition
Implication Area	**Comment(s)**
Legal/Legislative:	Departmental Analysis: 1. Legislature would have to lift local option limitation. 2. Depending on timing may require review of sunset clause. Stakeholder Comments: 1. This criminalizes mental illness. Client advocate/service provider 2. "Black robe effect" is powerful; however, Laura's law has no other enforcement power. Judges have no contempt power in Laura's Law; their only tool is harsh language. Community advocate/attorney Written comments: 1. AB 1569 passed the legislature and was signed by the Governor extending the sunset to 2017. Member, Treatment Advocacy Coalition
Implication Area	**Comment(s)**
Individual Impact::	Departmental Analysis: 1. It might decrease perception of personal autonomy by appearing to require compliance with outpatient treatment as a condition for remaining free of detention. 2. May increase the perception by families of ability to obtain outpatient treatment for loved ones. 3. Might decrease personal autonomy by empowering families to request AOT. Stakeholder Comments: 1. Creates disengagement from process. Patients' rights advocate 2. Could limit access to other resources in cash-strapped counties forced to adopt AOT. Administrator

Recommendation #10:	**Implement Assisted Outpatient Treatment (Laura's Law) statewide.**
Implication Area	**Comment(s)**
Individual Impact: (continued)	Written Comments: 1. Individuals getting mental health services or wanting mental health treatment living in counties that cannot afford to implement Laura's Law may lose services due to counties being forced to implement assisted outpatient treatment regardless of the county's ability to pay for AOT. Unknown How to strike a balance between individual lack of compliance with providers who will financially be penalized for not "managing the patient's health". Local hospital association representative 2. #1 is just simply wrong. No client can be detained unless they meet criteria under WIC 5150. #2 is simply anti-family and infers that if families were aware of resources that might save the life of someone they loved, this would be wrong? #3 infers that families might abuse an ability to petition for AOT rather than as a tool to prevent someone they love from coming to harm. The specifics written into the law will maintain fidelity and accountability that no one should be wrongfully court-ordered to treatment unless they met the exacting criteria of AB 1421. Member, Treatment Advocacy Coalition

Recommendation #11:	**Expand mental health courts in all jurisdictions and increase the capacity and utilization of current mental health calendars statewide.**
Implication Area	**Comment(s)**
Clinical:	Departmental Analysis: 1. Would likely impact clinician time commitments to judicial processes. Stakeholder Comments: 1. This would require special training for clinicians. Community advocate/attorney 2. This would increase clinical care and decrease incarceration for those in mental health court: therapeutic jurisprudence. Member, Treatment Advocacy Coalition
Implication Area	**Comment(s)**
Programmatic:	Departmental Analysis: 1. Would require significant increased resources from those agencies necessary for mental health judicial resources: departments of mental health, public guardians, public defenders, public and private hospitals. 2. Would require significantly increased judicial resources. Stakeholder Comments: 1. This would require expansion of pts rights offices and resources. Patients' rights advocate 2. Would make law enforcement less likely to arrest, as to take to hospital. Community advocate/law enforcement officer 3. Mental health court linkage program: this is a more flexible approach that supplies clinicians to courts across the county, as opposed to having special mental health court. Mental Health Counselor/court administrator 4. Safety realignment and AB109 experience suggests that mental health programs aren't always working, and rather than going to jail or prison. Mental health court may be looking to conservatorships and PG to solve problem of individuals with long criminal history, and this is problematic and sometimes dangerous and inappropriate. Deputy public guardian 5. The failure of such adjudicated people sends them to hospitals, who are not equipped to handle this level of violence and criminality. Mental Health Counselor/court administrator 6. This proposal could be limited to new offenders. Member, Treatment Advocacy Coalition 7. We should focus on new offenders; not AB109. Community advocate/law enforcement 8. Perhaps a collaborative mental health court dedicated to AB109 would be useful. Patients' rights advocate/attorney 9. This may require special judges, not just circuit riders. Community advocate/attorney Written comments: 1. This recommendation was not intended to identify the configuration of a mental health court, calendar, or court process. One configuration for one county will not satisfy the needs of another. What works in a small or mid-sized county may not be feasible in a larger county such as Los Angeles, and vice-versa. The point is that jail diversion works, it saves lives, and well worth the costs incurred. Studies have shown savings over the long term. Continued recidivism for people with serious mental illness is just not good policy, fiscal or otherwise. Member, Treatment Advocacy Coalition

Recommendation #11:	**Expand mental health courts in all jurisdictions and increase the capacity and utilization of current mental health calendars statewide.**
Implication Area	**Comment(s)**
Fiscal:	Departmental Analysis: 1. Would increase costs associated with expanded mental health courts. Stakeholder Comments: 1. There are obvious fiscal implications. Mental Health Counselor/court administrator
Implication Area	**Comment(s)**
Legal/Legislative:	Departmental Analysis: 1. No additional analysis Stakeholder Comments: 1. Legal community will express considerable opposition to this recommendation due to increased legal processes, costs, etc. involved. Written Comments: 1. None
Implication Area	**Comment(s)**
Individual Impact:	Departmental Analysis: 1. Depends on whether Mental Health Courts are voluntary or involuntary. 2. Increased access to mental health courts may affect perception of personal independence from judicial processes. 3. Increased access to MHC would mean that more individuals with MH issues would be sent to these courts which could lead to a perceived decrease of criminalization 4. Depending on nature of proceedings, could decrease incarceration of individuals with mental illness. Written comments: 1. #1 All mental health courts are voluntary. #2 When one has committed a criminal offense, there is no personal independence from judicial processes. #3 What we need is less criminalization of persons with serious mental illness. And I hope someone would notice. Member, Treatment Advocacy Coalition

Recommendation #12:	Conform local emergency response capability in each county under a legislative framework that requires standardized training for all designated response entities.
Implication Area	**Comment(s)**
Clinical:	Departmental Analysis: 1. Assuming that "designated response entities" refers to individuals with LPS detention authority would require the development of presumptively clinical training curricula for a variety of workers, including clinicians of various licensures, all law enforcement personnel, and others. 2. Would likely lead to more uniform determinations of probable cause under WIC 5150. Written Comments: 1. As part of standardized training, open the training to interested staff at non-designated hospitals. Individuals who intentionally abuse this can be decertified. This will then reduce unnecessary detention - when appropriate move people to appropriate setting. Local hospital association representative
Implication Area	**Comment(s)**
Programmatic :	Departmental Analysis: 1. Would require development, certification, and ongoing operation of training programs in unspecified agencies. 2. Would require resource allocation by agencies employing LPS authorized individuals (including law enforcement agencies) to support training and backfill employee time. Stakeholder Comments: 1. This would require time consuming updates. It could work under command of one system, and should include emergency responders beyond law enforcement; e.g. fire. Community advocate/law enforcement officer 2. This should include fire department. Law enforcement doesn't make medical decisions except mental health. And law enforcement already receives a large amount of state-mandated training. Community advocate/law enforcement 3. We call law enforcement because response is quick and they restore order. Community advocate/city administrator 4. We should train those in prison about mental health issues, and use them as trainers in new programs. Community/patient advocate 5. Law enforcement training (e.g. CIT) is ongoing, but law enforcement first responders are generalists, baseline training may not be the best approach. Might need a targeted training. Also, lack of mandated treatment upfront creates problems downstream. Community advocate/law enforcement 6. The proposal should clarify whether or not the intent of this is to mandate training for all individuals with LPS detention authority. Mental health administrator

Recommendation #12:	**Conform local emergency response capability in each county under a legislative framework that requires standardized training for all designated response entities.**
Implication Area	**Comment(s)**
Fiscal:	Departmental Analysis: 1. Would require funding for curriculum development and certification and operation of training agencies. Stakeholder Comments: 1. There is recovery of the training resources through decrease in lawsuits that result from lack of training. The training reduces violence by training to de-escalate situations. Member, Treatment Advocacy Coalition
Implication Area	**Comment(s)**
Legal/Legislative:	Departmental Analysis: 1. Would require legislative action to mandate under WIC 5000 training for LPS authorized individuals. Written Comments: 1. Liability: Who assumes this if non-designated hospitals must release individual when PMRT does not respond within the appropriate windows of time? Local hospital association representative
Implication Area	**Comment(s)**
Individual Impact:	Departmental Analysis: 1. Depending on the content of training and good will of person being strained, standardized trainings could lead to safer experiences for individuals with mental health issues. Stakeholder Comments: 1. The described curriculum could be seen as insulting to mentally ill individuals who face danger from law enforcement. Client advocate

Recommendation #13:	**Set uniform state custodial standards for who can generate a 5150 hold and clarify who can enforce, release or continue that hold.**
Implication Area	**Comment(s)**
Clinical:	Departmental Analysis: 1. Depending on any changes in current standards may affect clinical practice. Stakeholder Comments: 1. Depending on what legislators do, it could have an impact on law enforcement's role by taking them out completely. Written Comments: 1. None
Implication Area	**Comment(s)**
Programmatic:	Departmental Analysis: 1. To the extent that such standards differ from those currently in place, would require programmatic changes in agencies that participate in WIC 5150 processes. Stakeholder Comments: 1. This could remove all or some law enforcement, with major results. Community advocate/law enforcement officer 2. Expanding beyond LPS designated facilities, with mandated review by local DMH, creates issues for monitoring and reviewing the facilities. Community advocate/private psychiatrist 3. It is critical to define coordination requirements between LPS designated facilities and non-designated emergency rooms. Especially applicable to individuals brought in on hold by law enforcement to non-designated facilities, and attendant liability exposure. Local hospital association representative 4. Detained individuals in non-designated facilities may require medical treatment that precludes transfer to designated facilities. Community advocate/city administrator 5. EMTALA standards must be conformed. The issue is EMTALA, not LPS. EMTALA should have safe harbor or something to deal with holding individuals who won't consent to treatment or detention. Immune from civil liability under WIC 1799. Community advocate/attorney 6. Could force LPS designated facilities to accept from non-designated facilities. Community advocate/law enforcement officer 7. An issue for non-designated is lack of response by PMRT or others. Local hospital association representative 8. The issue is holding people in non-designated is a dead-end as it stands right now; they often can't be kept and can't be transferred. Community advocate/city administrator 9. This address issues of crossing county lines and encountering different rules. Member, Treatment Advocacy Coalition 10. Law enforcement should have funding sources. Community advocate/law enforcement officer

Recommendation #13:	**Set uniform state custodial standards for who can generate a 5150 hold and clarify who can enforce, release or continue that hold.**
Implication Area	**Comment(s)**
Fiscal:	Departmental Analysis: 1. To the extent that standards differ from those currently in place, could increase or decrease costs for various agencies and facilities, related to operating expenses and liability exposure. Stakeholder Comments: 1. Fund all agencies and provide them access to Medi-Cal, including law enforcement, fire department, jails, so that they can continue to operate functionally. Written Comments: 1. None
Implication Area	**Comment(s)**
Legal/Legislative:	Departmental Analysis: 1. To the extent that such standards differ from those currently in place, would require legislative changes. Written Comments: 1. Liability: Who assumes liability if non-designated hospitals must release patient or is asked by local DMH that they cannot detail an individual beyond their time if PMRT does not respond within a designated window? Local hospital association representative
Implication Area	**Comment(s)**
Individual Impact:	Departmental Analysis: 1. To the extent that such standards differ from those currently in place, may increase or decrease personal autonomy. Stakeholder Comments: 1. As long as standards clarified are uniform, that would be helpful to clients. Patients' rights advocate Written Comments: 1. Individuals may experience "custodial standards" as a euphemism for making 5150 holds easier to generate, enforce and continue and more difficult to release. 2. What reduces personal autonomy is when one jurisdiction uses different practices from another producing a wide disparity in the quality of the services provided. All counties should utilize best practices to ensure appropriate treatment of all persons with serious mental illness and trained to comply with uniform state custodial standards. Member, Treatment Advocacy Coalition

Recommendation #14:	**Ensure statewide uniform application of the Lanterman Petris Short Act to achieve equity and equal protection for all consumers statewide.**
Implication Area	**Comment(s)**
Clinical:	Departmental Analysis: 1. To the extent that any uniform application of the Lanterman Petris Short Act differs from practice in any given system, the uniform application would change clinical practice within the system. Stakeholder Comments: 1. Formulate strategies to get responders to low-density populations versus metropolitan high-density populations. Geography, methods of transportation, and clinicians should factor into the strategies.
Implication Area	**Comment(s)**
Programmatic:	Departmental Analysis: 1. Would require the development of a uniform application definition and methodology to measure deviation from that standard. 2. To the extent that any uniform application of the Lanterman Petris Short Act differs from practice in any given system, programs within the system would change. 3. May require explicit identification of permissible areas and extent of local discretion. Stakeholder Comments: 1. The application should take population density and other characteristics into account—there are different resources in different places. Community advocate 2. Statewide application of conservatorship component is made problematic, as conservatorship is under auspices of individual counties. Deputy public guardian 3. Lack of uniformity is based on local legal opinion—it will be difficult to override local court jurisdiction. Deputy public guardian 4. Statewide regulation can be helpful to help make application uniform. Like Reiss hold at second 14 should be uniform. Legislating what grave disability level is proper might not make sense. Statewide uniformity, where appropriate, can be legislated. Patients' rights advocate/attorney
Implication Area	**Comment(s)**
Fiscal:	Departmental Analysis: 1. To the extent that any uniform application of the Lanterman Petris Short Act differs from practice in any given system, costs within that system might change, but direction of change may vary. Additional Comments: 1. No additional comments.

Recommendation #14:	**Ensure statewide uniform application of the Lanterman Petris Short Act to achieve equity and equal protection for all consumers statewide.**
Implication Area	**Comment(s)**
Legal/Legislative:	Departmental Analysis: 1. To the extent that any uniform application of the Lanterman Petris Short Act differs from practice in any given system, elements of that system may seek legal remedies to avoid compliance. 2. Requires statutory changes. Stakeholder Comments: 1. Some of the conservatorship issues regarding uniformity may be decided by the courts.
Implication Area	**Comment(s)**
Individual Impact:	Departmental Analysis 1. To the extent that any uniform application of the Lanterman Petris Short Act differs from practice in any given system, personal autonomy within the system may be affected, either through increase or decrease. Written Comments: 1. Depending on the individual's ethnic or cultural perspectives, the attempt to "ensure statewide uniform application" of LPS might be experiences as inequity rather than equity.