

Q and A regarding State Audit of LPS Act

What is the Los Angeles County Department of Mental Health's overall response to the State's audit of the Lanterman-Petris-Short Act?

The audit did not give the legislators the road map for reform that was requested and that we had hoped. It does have some valuable findings, but pieces of the report are inaccurate and/or misconstrued, despite input that was provided by the Los Angeles County Department of Mental Health (LACDMH) as part of the audit process.

Most importantly, it was incomplete based on its charge, in that it fell short by failing to analyze the Lanterman-Petris-Short Act (LPS) Act in light of what we know now, about how serious mental illness, and neuropsychiatric disorders in general, can profoundly impact the insight, judgement and decision-making needed to live safely in the community.

It is in aspects of serious mental illness, often described as "anosognosia" in the neurology literature, that make treatment engagement impossible for certain clients at certain times over the course of their illness and compel our system to leverage involuntary treatment as a tool of last resort for engagement.

In Los Angeles, we see it as both a disappointment and a missed opportunity. We have been working with members of the legislature and with the mental health community and leaders throughout California since 2018 on the need for reform of the LPS Act, specifically the need to revise criteria for "grave disability" and/or redefine criteria for involuntary treatment based on an individual's inability to live safely in community in such a way that it reflects our current understanding of the brain and behavior.

Reform must compel our state to double down on dedicated resources for any and all clients requiring conservatorship including:

1. A conservator with the time, motivation and capacity to provide adequate surrogate decision making
2. Guaranteed housing
3. An intensive outpatient clinical team, such as a Full Service Partnership (FSP), that is assigned and required to maintain care continuity for that person for the duration of the conservatorship
4. Access to a treatment bed, locked or unlocked, 24/7

The commitment of resources for conservatorship is necessary to provide a successful pathway for recovery and independence and, from our perspective, a successful conservatorship will mitigate the need for future conservatorships once an individual is properly supported and engaged in treatment for an adequate period of time.

Why are the criteria for "grave disability" and/or its redefinition so important?

In response to a rise in preventable deaths among the homeless, Los Angeles County first proposed redefining the LPS Act's criteria for "grave disability" in a 2017 Board of Supervisors' motion, at the instigation of the Department of Mental Health.

The issue of how “grave disability” is defined is vital because the current criteria and judicial process limit the engagement and services accessible to those who suffer from serious mental illness and, as a result, live on the streets and/or end up incarcerated.

The LPS Act embodies the best parts of the progressive civil liberties thinking of its era, the 1960s, when involuntary civil commitments were too easy to obtain. It is imperative that every individual be protected from a return to the abuses of the past. However, LPS Act advocates of that era did not have access to 50 subsequent years of medical and scientific research into the etiologies, pathophysiology and treatment of severe mental health conditions.

In addition, there has been 50 years of mental health not being a federal and state priority. Even now, in spite of the fact that mental health parity is now federal law, funding a behavioral health system that offers a proper continuum of care and placement/housing is still not a priority.

We now know what we didn’t know back then: that, with the current process, a person can appear adequately lucid and provide a narrative plan for accessing food, clothing and shelter in a conservatorship hearing despite being unable to live safely in community (and thereby meet the original justification to involuntarily treat those who are “gravely disabled”).

Engaging clients in a rational manner and helping them make life-saving choices about their care and helping them to follow up on such choices is next to impossible when that client lacks subjective insight, judgement and decision-making capacity regarding their medical or psychiatric condition (not to mention their impact on the safety of others in their community).

Instead of exploring these issues as we expected, the audit simply restated the basic principles of individual liberties that were the basis of the LPS Act in the late 1960s. The values of individual liberty matter greatly to us, but in LA County, with thousands of persons with severe mental and physical health conditions living on the streets, in jails or in juvenile halls, we believe it is cruel to withhold medical and psychiatric care from those who are unable to understand that they are ill and thereby refuse treatment.

What about the Public Guardian? Do you have any comments on the audit’s lack of recommendations related to the Office of the Public Guardian?

It was also both a surprise and a disappointment that 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.

The issues of the Public Guardian were directly related to the scope of the audit, specifically how counties fund their implementations of the LPS Act and whether access to funding is a barrier to the implementation; the answer is YES. We have nowhere near enough staff to manage our current caseload let alone a larger caseload and, per our comments above regarding the need for conservators with time, there is no time when conservators have caseloads double of what we would suggest is indicated.

While the auditors indicated they reviewed funding for Public Guardians and did not conclude it was a barrier to implementing the LPS Act, their conclusion is in stark contrast with the reality of the trenches locally (and statewide) given that public guardian offices are chronically underfunded, have difficulty recruiting and maintaining staff and carry caseloads completely unacceptable to the depth and scope of their responsibilities.

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 clients is subject to the availability of realignment funding and county general funds. The audit's failure to consider this fragile element of the mental health system, or propose recommendations to strengthen it, limits its relevance to reform efforts and demonstrates quite clearly our concern that this audit report ignores the realities communicated by the department doing the work.

What is your response to the claim that “only 9 percent” out of 7,400 LPS hold in Los Angeles County over a two-year period were enrolled in what the audit calls “subsequent care,” referring to Full Service Partnerships or Assisted Outpatient Treatment?

This claim is based on an incomplete and erroneous understanding of the population of LPS holds in Los Angeles County. Not all clients hospitalized for brief holds should be referred to a Full Service Partnership (FSP) level of care; in fact, many holds end up being applied based on the unmet social needs of clients whose report and/or evaluation drive the application of short-term involuntary detention (i.e., 5150) when not appropriate.

There are many reasons clients are put on holds, and various mental entities that can place a client on a hold. Very brief holds can be due to instances like a business complaining about someone who is homeless or police responding to someone who is using substances.

Many people on brief holds end up staying for less than even 24 hours, let alone 3 days. Even if a client has 5 brief holds in 3 years (the auditors' criteria), he or she may not have the level of acuity or even a primary mental illness that would indicate FSP as the appropriate level of care. While these individuals may need mental health treatment, outpatient services are most often the appropriate level of care.

FSP is a high intensity, 24/7 program, reserved for our highest acuity clients. Both length and frequency of inpatient stays should be considered in assessing for who might need FSP services. When looking at the mental health histories of enrolled and former FSP clients, many have multiple, lengthy inpatient stays.

The auditors admit in the text of the audit that the appropriate treatment following a hold depends on the patient and will be chosen from among of a range of options. We agree with that. So, it is inconsistent that the audit made a headline out of the fact that only 9% received **intensive** services. They don't provide information about the other 91%, many of whom would not accept care, are beneficiaries of other plans and/or were connected with other, less intensive services that were appropriate for their conditions including prevention services, wellness center visits and/or therapy sessions, which are less intensive than FSP or Assisted Outpatient Treatment (AOT).

Is arranging for “subsequent care” upon discharge a responsibility of LA County?

As the audit pointed out, under US Department of Health and Human Services guidelines, meaningfully improving an individual’s prospects after crisis intervention requires good discharge planning. However, under those guidelines, discharge planning is the responsibility of the facility/hospital.

If LA does not know about the 5150’s (as confirmed by their report) and the hospital does not inform LACDMH how can LACDMH be held accountable for the number of individuals who receive follow up treatment? We advocate for a comprehensive discharge plan that is fully staffed and clearly communicated.

Of note, for the past 2 years LACDMH has been developing strategies to compel hospital compliance with discharge planning and contract modifications to implement across the entire network of acute and subacute facilities to this effect are anticipated during this fiscal year.

The auditors studied 20 conservatorships that LACDMH sought to extend in court and found that 10 out of the 20 were ended despite the LACDMH’s recommendation, and that 6 of the 10 allegedly ended due to doctors failing to appear in mental health court.

Conserved individuals have a right to contest their conservatorship and demand a jury trial, and in those cases, the patient’s doctor will be requested to testify to confirm their grave disability.

LACDMH reported the problem of doctors being unavailable for conservatorship hearings in a February 2019 report to the Board of Supervisors. In that report, the Office of the Public Guardian stated that almost 20 percent of the conservatorships that ended in FY 2017-18 did so because the doctors of conserved individuals did not testify in court. LACDMH notifies the courts of the days the doctors are available, but the courts have scheduled hearings on dates when the court knows the doctors will not be available.

These physicians cannot bill Medi-Cal or any other insurer for any court related activities on behalf of their clients. In most cases, the physicians are not LACDMH staff. Testimony is provided either by the treating physician or by a physician contracted by a facility to evaluate and testify about grave disability.

As a result of the Sanchez ruling, forensic testimony is restricted to their personal observations rather than the medical record and data from non-treating clinicians, family, friends and others familiar with their ability to live safely in the community is excluded. Further, clinicians are often unable to testify using the medical record because it is considered hearsay. So, the audit recommendation to use LACDMH doctors would not be a solution. Many facilities contract with a forensic doctor instead of using their treating doctor. However, this recommendation wouldn’t change the underlying problem: they cannot testify to the medical record – only their direct observations.

To address these issues, LACDMH made several recommendations on this matter to the auditors, including:

- Amending state law to allow medical experts to permit forensic testimony about the medical record as an alternative to requiring the physician who made the record to testify in person
- Amending state law to allow for tele-testimony in LPS conservatorship hearings and trials. This would have the additional benefit of reducing unnecessary, sometimes unsafe transport of clients
- Logistical changes to the way Mental Health Court is scheduled so that testifying doctors are not required to wait hours to deliver their testimony

Do you have any comments on the alleged surpluses of MHSA funds, and the auditors' confusion over how MHSA dollars are budgeted and managed?

The audit implies that unspent MHSA funds are those that counties have not accounted for or used in any way. They claim we and other counties are sitting on MHSA funds without serving those with mental illness. This is completely untrue.

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 that are already in the LACDMH budget and 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.

It is also important to reiterate that MHSA revenue is volatile due to being based on income tax and allocations determined by the California Department of Health Care Services (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.

With roughly one-quarter of the state's population, Los Angeles County receives the largest share of MHSA funds. LACDMH has used MHSA funds to provide a broad continuum of community-based prevention, early intervention and other services for LA County residents with severe mental illnesses.

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